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MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE

DEVELOPMENTAL  
COLLECTION

AUG 13 1993

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# MASSACHUSETTS MEDICAL ASSISTANCE



## PROCEDURES HANDBOOK

931/77



# Check List of MA - Transmittals Received

TN	Date	Initial	TN	Date	Initial	TN	Date	Initial	TN	Date	Initial
1.			37.	<u>1-13-83</u>		73.	<u>10-25-83</u>		109.	<u>5-17-85</u>	
2.	<u>1-25-82</u>		38.	<u>1-14-83</u>		74.	<u>10-27-83</u>		110.	<u>5-29-85</u>	
3.	<u>1-26-82</u>		39.	<u>2-18-83</u>		75.	<u>11-23-83</u>		111.	<u>7-26-85</u>	
4.	<u>rescinded by #8</u>		40.	<u>2-18-83</u>		76.	<u>12-5-83</u>		112.	<u>8-1-85</u>	
(3-16-82) 5.	<u>3-3-82</u>		41.	<u>2-2-83</u>		77.	<u>12-8-83</u>		113.	<u>8-15-85</u>	
6.	<u>3-8-82</u>		42.	<u>3-8-83</u>		78.	<u>12-13-83</u>		114.	<u>8-15-85</u>	
7.	<u>3-15-82</u>		43.	<u>3-18-83</u>		79.	<u>12-22-83</u>		115.	<u>9-15-85</u>	
8.	<u>3-18-82</u>		44.	<u>4-15-83</u>		80.	<u>1-11-84</u>		116.	<u>9-15-85</u>	
9.	<u>3-29-82</u>		45.	<u>4-29-83</u>		81.	<u>1-11-84</u>		117.	<u>10-21-85</u>	
10.	<u>3-30-82</u>		46.	<u>5-17-83</u>		82.	<u>2-1-84</u>		118.	<u>12-15-85</u>	
11.	<u>4-9-82</u>		47.	<u>5-25-83</u>		83.	<u>3-2-84</u>		119.	<u>2-15-86</u>	
12.	<u>5-15-82</u>		48.	<u>5-27-83</u>		84.	<u>3-2-84</u>		120.	<u>5-15-86</u>	
13.	<u>5-27-82</u>		49.	<u>5-27-83</u>		85.	<u>4-7-84</u>		121.	<u>6-15-86</u>	
14.	<u>6-2-82</u>		50.	<u>5-27-83</u>		86.	<u>4-17-84</u>		122.	<u>7-15-86</u>	
15.	<u>6-10-82</u>		51.	<u>6-2-83</u>		87.	<u>4-24-84</u>		123.	<u>8-15-86</u>	
16.	<u>7-2-82</u>		52.	<u>6-3-83</u>		88.	<u>5-1-84</u>		124.	<u>9-15-86</u>	
17.	<u>7-6-82</u>		53.	<u>6-3-83</u>		89.	<u>5-16-84</u>		125.	<u>10-15-86</u>	
18.	<u>7-12-82</u>		54.	<u>6-10-83</u>		90.	<u>5-23-84</u>		126.	<u>10-15-86</u>	
19.	<u>7-19-82</u>		55.	<u>6-14-83</u>		91.	<u>6-1-84</u>		127.	<u>11-15-86</u>	
20.	<u>7-28-82</u>		56.	<u>6-16-83</u>		92.	<u>6-5-84</u>		128.	<u>11-15-86</u>	
21.	<u>8-18-82</u>		57.	<u>7-1-83</u>		93.	<u>7-6-84</u>		129.	<u>11-15-86</u>	
22.	<u>8-27-82</u>		58.	<u>7-7-83</u>		94.	<u>7-17-84</u>		130.	<u>12-15-86</u>	
23.	<u>9-2-82</u>		59.	<u>7-7-83</u>		95.	<u>8-23-84</u>		131.	<u>1-15-87</u>	
24.	<u>9-2-82</u>		60.	<u>7-11-83</u>		96.	<u>8-23-84</u>		132.	<u>1-15-87</u>	
25.	<u>9-2-82</u>		61.	<u>7-14-83</u>		97.	<u>8-31-84</u>		133.	<u>2-15-87</u>	
26.	<u>9-9-82</u>		62.	<u>7-21-83</u>		98.	<u>9-27-84</u>		134.	<u>3-15-87</u>	
27.	<u>9-13-82</u>		63.	<u>7-22-83</u>		99.	<u>11-7-84</u>		135.	<u>4-15-87</u>	
28.	<u>9-27-82</u>		64.	<u>7-29-83</u>		100.	<u>12-19-84</u>		136.	<u>4-15-87</u>	
29.	<u>10-15-82</u>		65.	<u>8-5-83</u>		101.	<u>2-7-85</u>		137.	<u>5-15-87</u>	
30.	<u>12-22-82</u>		66.	<u>8-16-83</u>		102.	<u>2-13-85</u>		138.	<u>7-15-87</u>	
31.	<u>11-1-82</u>		67.	<u>8-22-83</u>		103.	<u>2-19-85</u>		139.	<u>7-15-87</u>	
32.	<u>11-10-82</u>		68.	<u>8-31-83</u>		104.	<u>2-19-85</u>		140.	<u>9-15-87</u>	
33.	<u>12-3-82</u>		69.	<u>9-21-83</u>		105.	<u>4-4-85</u>		141.	<u>10-15-87</u>	
34.	<u>12-24-82</u>		70.	<u>9-22-83</u>		106.	<u>4-1-85</u>		142.	<u>12-15-87</u>	
35.	<u>12-31-82</u>		71.	<u>9-22-83</u>		107.	<u>4-19-85</u>		143.	<u>1-15-88</u>	
36.	<u>1-12-83</u>		72.	<u>9-30-83</u>		108.	<u>5-15-85</u>		144.	<u>1-15-88</u>	

# Check List of MA - Transmittals Received

TN	Date	Initial	TN	Date	Initial	TN	Date	Initial	TN	Date	Initial
145.	1-15-88		181.			217.			253.		
146.	2-15-88		182.			218.			254.		
147.	3-15-88		183.			219.			255.		
148.	3-15-88		184.			220.			256.		
149.	3-15-88		185.			221.			257.		
150.	4-15-88		186.			222.			258.		
151.	4-15-88		187.			223.			259.		
152.	5-15-88		188.			224.			260.		
153.	10-15-88		189.			225.			261.		
154.	10-15-88		190.			226.			262.		
155.	11-15-88		191.			227.			263.		
156.	12-15-88		192.			228.			264.		
157.	2-15-89		193.			229.			265.		
158.	4-15-89		194.			230.			266.		
159.	4-15-89		195.			231.			267.		
160.	3-15-89		196.			232.			268.		
161.	7-15-89		197.			233.			269.		
162.	8-15-89		198.			234.			270.		
163.	9-15-89		199.			235.			271.		
164.	11-15-89		200.			236.			272.		
165.	12-15-89		201.			237.			273.		
166.	1-15-90		202.			238.			274.		
167.	1-15-90		203.			239.			275.		
168.	2-15-90		204.			240.			276.		
169.	3-15-90		205.			241.			277.		
170.	7-15-90		206.			242.			278.		
171.	9-15-90		207.			243.			279.		
172.	12-15-90		208.			244.			280.		
173.	12-15-90		209.			245.			281.		
174.			210.			246.			282.		
175.			211.			247.			283.		
176.			212.			248.			284.		
177.			213.			249.			285.		
178.			214.			250.			286.		
179.			215.			251.			287.		
180.			216.			252.			288.		

***THE EXAMPLES USING  
CALCULATIONS IN THIS  
HANDBOOK ILLUSTRATE  
METHOD ONLY. THE FIGURES  
MAY NOT REFLECT CURRENT  
BUDGETS OR ELIGIBILITY  
STANDARDS***

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YOUR DEPARTMENT OF PUBLIC WELFARE  
MA WORKER HANDBOOK

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# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

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# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

## GLOSSARY OF TERMS

### Bendex

The SSA Beneficiary Data Exchange (Bendex) provides an automatic exchange of information concerning retirement, survivors and disability insurance (RSDI) benefits between State Welfare Agencies and the Social Security Administration (SSA).

### Blue Cross/Blue Shield

Non-profit private health insurance agency, which in Massachusetts, administers claims made on Medicare.

### Buy-In

A process whereby the State (DPW) buys part B medical Coverage of Medicare for certain SSI eligible needy individuals.

### CAMS

Case Administration and Management System (The Turnaround Document)

### Disallowance Code

Each provider who submits invoices or bills to the Department for medical services rendered to eligible recipients receives in return a Claim Remittance Advice. The CRA explains which bills are being paid and why others are disallowed. By examining the disallowance code, the provider and/or worker will know why the claim was disallowed. The worker must take remedial action for the following codes G, I, J, K and M. (See processing instructions for PA-9A Forms 7510 ff.)

### Medical Division

Division of Medical Assistance or Medical Division is located at Central Office and is responsible for: Maintenance of Provider Eligibility Records, Provider Surveillance, Contractor Interface, Peer Review of Medical Claims, Project Good Health or EPSDT, Contents of Medical Care Plan.

### EPSDT

Early Periodic Screening Diagnosis and Treatment Program. In Massachusetts it is called Project Good Health. It is a program designed to provide preventive health services for children.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

## Glossary of Terms (con't)

### Exemption Table

A table used in Medical Assistance eligibility displaying the amount of money exempted for maintenance cost or basic needs. The table figure varies with the number of persons to be considered.

### FMCS

Financial Management Control System ("Recipient Master File").

### Gold Check

The U.S. Treasury check issued for the Supplemental Security Income Program. Unlike other U.S. Government checks, it is gold in color. (Note: It is important to be able to distinguish this check from others.)

### Green Check

The U.S. Treasury check issued by the Social Security Administration for RSDI benefits.

### H.M.O.

Health Maintenance Organization. A free standing health organization with predetermined membership. Medicaid pays for services for Medicaid eligible members.

### Level of Care

Refers to the intensity of care a person receives in a nursing home. (Note: see training segment on Nursing Home Care).

### LTCF

Long Term Care Facility

### MA-ID Card

An identification card containing the name and category of eligible persons. Issued manually or by computer. It is presented by recipients to provider at time of medical service.

### Recipient Master File (RMF)

A printout generated by computer containing the name and category 0-9 of all recipients of Public Assistance. (FMCS)

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

## Glossary of Terms (con't)

### Medex

A private insurance plan that individuals or groups can buy from BC/BS. It is the most commonly known supplement to Medicare coverage.

### M.M.I.S.

Medical Management Information System. A computer system that is used in administration of Medicaid. It is in the process of being developed in Massachusetts.

### P.N.A.

Personal Needs Allowance allowed for personal needs when a person is a nursing home patient.

### PGH

Project Good Health

### Pilgrim Health Applications

A claims processing firm which processes selected claims under the Medicaid program. Providers send claims for dental services, pharmacy services and general medical services to Pilgrim Health Applications, Bedford, Mass.

### Piggy-Back System

When a recipient of Medicaid has Medicare Part-B coverage and the Fiscal Intermediary is Blue Shield of Mass., the physician submits the claim on a Medicare Claim Form (not MA-7) at Blue Shield. If the service is reimbursable by Medicare, the amount of reimbursement made by the Department is based on the Medicare Amount approved. Medicare Part B pays 80% of the Medicare Amount approved, and the Department automatically (through the "piggy-back system") pays the 20% coinsurance balance plus the deductible amount.

### Prior Approval

For some Medicaid services, the provider must obtain a "prior approval" from the Medical Division before performing the service, e.g., expensive, elective or high frequency services.

### Private Carrier

Any health insurance company such as Blue Cross/Blue Shield, Aetna, John Hancock, Metropolitan Life, Harvard Community Health Plan, etc. A provider must submit bills to the private carrier before they are submitted to Medicaid.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

## Glossary of Terms (con't)

### PSRO

Professional Standards Review Organization. A review system of the need for Nursing Home Care and other related services.

### RDCU

Regional Data Contrc t

### SDX

State Data Exchange. A system that provides information concerning SSI recipients to the Department.

### Split Bill

A situation where an applicant has sufficient income or available income to apply to part of a bill while the Department assumes liability for the remainder of same bill.

### SMRT

State Medical Review Team.

### SSI

Supplemental Security Income. A Federal-State program based on need; for the elderly and disabled. (a cash payment program)

### SSA

Social Security Administration.

### TD

Turnaround Document. Used to make entries, changes and closings on the Masterfile.

### VRER-20

Vendor Recipient Eligibility Listing. A computer printout issued bi-monthly of all past and present Medicaid eligible recipients. (including start and close dates).



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

## LIST OF COMMONLY USED FORMS

### A-16 (Third Party Lien Form)

Whenever there is a possibility of a recovery because of third party liability involving an accident, injury, disease or death, Assignment Form-16 must be completed and signed giving the Department the right to bring claim.

### Leg. I & II

LEG Forms I and II are the instruments by which appropriate recoveries are made through the Legal Division. Leg II Form is completed by the CSA/WSO and Leg I is completed by the Chronic Care Facility.

### MA-1

A cover letter notifying a recipient that his eligibility must be redetermined.

### MA-Invoice

An Invoice form required by the Department for use by medical providers for medical services rendered to a recipient.

### MCCC-1

A form, completed by provider and worker when a disallowance code M or 13 (Ineligible Clients for Dates of service billed) is received by physician. The form is used to verify dates and by-pass the vendor file for correct payment.

### PA-32

Non-Standard Medical Invoice Summary sheet. A summary form completed by worker and sent to MCCC when processing spenddown cases. Its intent is to prevent double billing and identify recipient liability.

### PA-37

Surplus Income Data Sheet. A worksheet used in Surplus Income cases to determine start date, spend-down and bills applied to spend-down.

### PA-9A

An adjustment form used to correct original bills submitted on MA or PA-9 invoice (see instructions on PA-9A).

### P.I.-1

The form by which the long term care facility and the recipient are informed of the recipient's patient paid amount.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

## List of Commonly Used Forms (con't)

### SC-1

Status Change notice sent by long-term-care facility to WSO/CSAO when possibly Medicaid-eligible patient is admitted (or discharged).

### SS-37

Application for Medical Assistance

### SS-37A

Application for "Retroactive" eligibility for Medicaid. (up to three months prior to month of application SS-37)

### SS-32

A "Medical Report Form" which is completed by physician and becomes part of the Department's case record.

### SS-33

Disability Assistance Report for MA-DA cases.

### Third Party Assignment

(See A-16).

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

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3000: OVERVIEW OF BASIC ELIGIBILITY REQUIREMENTS

All individuals who apply for Medical Assistance must meet certain basic requirements prior to establishing categorical or financial eligibility. The basic requirements for the Medical Assistance Program are:

- A. residence in Massachusetts;
- B. U.S. citizenship or alienage;
- C. a social security number (SSN) or an application for a social security number (SSN);
- D. utilization of potential benefits; and
- E. assignment for third party recoveries/medical support.

Workers must determine if applicants or recipients meet these requirements before considering other requirements for MA eligibility.



3100: Residence3101: Elements of Residence

Two basic conditions must be met by all persons, unless otherwise exempted, in the establishment of residency: to be "living in the Commonwealth" and an intent to remain in the Commonwealth, although not necessarily permanently.

The primary requirement is that the applicant or recipient be living in the Commonwealth of Massachusetts although he or she is not required to maintain a permanent address.

3102: Verification of Residence

Applicants and recipients must provide the worker with verification of residence, in accordance with Section 503.100 of the MA Policy Manual. (See 3106 for exceptions to this rule.)

NOTE: Homeless recipients may have their MA-ID cards sent to the post office box or the welfare office which covers the area in which they live.

3105: Intent to Reside

An intent to reside, with no present intent of leaving, is the second factor of residence.

An individual is not required to intend to remain in Massachusetts for a fixed period of time.

EXAMPLES: Examples of persons who do not have a present intent to reside are:

- A. an individual who enters the Commonwealth for the purpose of receiving medical care with no plans to remain after treatment;
- B. visitors and diplomats who intend to return to a prior residence.

When an individual states an intent to leave the Commonwealth, residence cannot be established. However, when an individual appears to intend to leave but states that he or she intends to remain, this statement must be accepted unless evidence exists to the contrary.

EXAMPLES: Examples of evidence to the contrary are:

- A. a contract for employment in another state; and
- B. a permanent residence in another state.

Persons who are not required to establish intent to reside are:

- A. persons living in Massachusetts who entered Massachusetts for a job or to seek employment; (see 3106)
- B. persons placed by Massachusetts public agencies in institutions located in other states; (see 3130)
- C. institutionalized persons under the age of 21; and
- D. persons incapable of indicating intent as described in Section 3120.

3106: Residence for Employment Purposes

Recent federal regulations were revised to allow medical coverage to persons who perform seasonal work in a state and consequently are not able to meet the residence requirement of intent.

## 3106 (Con't)

Regulations now provide that any individual who enters the state to fulfill a job commitment or to seek employment meets the residency requirement even if this individual does not intend to remain in the state and even if the employer is unable to keep the commitment or employment is not found.

If an applicant/recipient is unable to verify an identifiable residence, and has entered the state for employment purposes, he may meet the residence requirement by verifying that he has a job commitment or is seeking employment.

Acceptable verification of residency for employment purposes is a written statement from an employer, or a current DES registration card. In this type of case, workers must determine if the applicant is a recipient of public assistance in another state prior to determining eligibility.

3107: Former Recipients of Assistance in Another State

If the applicant is a recipient of assistance through another state, he remains a resident of that state until assistance is terminated. Termination of assistance in another state must be verified by a termination letter or a statement from the agency administering the program.

3110: Temporary Absence

An applicant or recipient who is temporarily absent from the state for 30 days or less meets the residency requirement for Medical Assistance if he can verify an identifiable residence in Massachusetts (see 3103) or provides a statement that he intends to continue to reside in the State. If the temporary absence continues for more than 30 days, the applicant or recipient must provide verification of the reason for the extended absence:

- A. medical records indicating that illness prevented his return;
- B. short term business contract;
- C. records of school attendance; and
- D. statement that recipient is visiting family or vacationing.

In addition, the applicant/recipient must provide verification of an identifiable residence in Massachusetts.

EXAMPLE:

Example. A 20 year old who lives with a roommate and works in Massachusetts, visits his parents in Idaho. While visiting he is hospitalized for injuries resulting from a car accident. He calls his roommate asking him to apply for MA in Massachusetts. The roommate can verify the applicant's residence by bringing in a copy of their lease to the local office. If the absence continues for more than thirty days, the recipient would have to provide copies of medical records indicating that the absence was necessitated by his condition.



3120: Residence of Institutionalized Individuals

Individuals who are placed in institutions by Massachusetts agencies or agencies of other states remain residents of the state that makes the placement. Applicants who are residents in institutions located outside the state must verify that they were placed by a public agency of Massachusetts.

In determining the residence of an individual who was placed in an institution by himself or his family, the worker must determine if the applicant is capable of indicating intent to reside in the institution.

Capability of Indicating Intent

An applicant is considered to be able to indicate intent unless he meets one of the following conditions:

- A. his I.Q. is less than 50;
- B. he has a mental age of less than 8;
- C. he is judged incompetent by a court;
- D. he is in a hospital for the mentally ill by order of a court; or
- E. documentation from a licensed physician or psychologist indicates that he is incapable.

An individual under 21 or who became incapable of indicating intent prior to the age of 21 is a resident of the state in which his parent or legal guardian resides.

An individual who became incapable of indicating intent after the age of 21 is a resident of the state in which he became incapable.

Therefore the worker must determine the age and residence of an applicant at the time he became incapable of indicating intent. The applicant's representative must verify this information by medical, court, or agency records indicating the date when the individual became incapable.

Individuals capable of indicating intent are considered residents of the institution in which they reside.

3121: Institutional Placements Across State Lines

A determination of residency for persons in institutions in other states, or for persons from other states placed in Massachusetts, is dependent on the conditions of the placement as detailed in this section.

A person is considered a resident of Massachusetts if a Massachusetts public agency (e.g.: Department of Public Welfare, Department of Social Services, juvenile court, etc.) arranged for the placement of the person in an institution located in another state.

If the placement has already been made, the worker must verify that the placement was made by a public agency. If the placement is being requested, the procedures of this section must be followed.

Procedures for Placement Out of State A request for placement of a

recipient in a specific out-of-state long-term-care facility must be initiated in the WSO/CSAO/LTCEU responsible for the recipient's case. The request for placement may be initiated by the recipient, the recipient's next of kin, or the representative (any person or organization that acts in the recipient's behalf including a guardian or conservator) and must include the following:

- A. Identification of the specific out-of-state facility in which the recipient is seeking placement;
- B. Documentation of the recipient's need for long-term-care services at the requested level of care; by means of entry form in Nursing Home, or SS-32 completed by a physician.
- C. Signed documentation of the hospital's efforts to place the recipient within the state, the reason why the recipient's admission was denied, and the date the recipient was designated an administrative case.

3122: Responsibilities of The WSO/CSAO/LTCEU

Once a request for out-of-state placement has been initiated, the WSO/CSAO/LTCEU worker responsible for the case must determine that the recipient is eligible for the Medical Assistance Program. If the recipient is deemed eligible, the WSO/CSAO/LTCEU worker then completes a Request for Prior Approval for Out-of-State Placement form and submits it together with the signed permission form and the medical necessity documentation to the Prior Approval Unit, Medical Division, Room 740, 600 Washington Street, Boston, MA 02111. In some circumstances, it may be necessary for the WSO/CSAO/LTCEU worker to obtain prior approval by telephone (617-727-1391). However, the WSO/CSAO/LTCEU worker shall then immediately forward the written request together with the permission form and the medical necessity documentation in the manner described.

3123: Responsibilities of the Prior Approval Unit

The Prior Approval Unit will assess a request for placement in the specific facility according to the criteria outlined below and will notify the WSO/CSAO/LTCEU worker of the prior approval decision within 3 working days of the receipt of the request. The WSO/CSAO/LTCEU worker is responsible for forwarding a notice to those initiating the request for out-of-state placement of the Prior Approval Unit's decision. When the request for placement has been denied, the notice must include an explanation of the recipient's right to a fair hearing and of the appropriate appeals procedures.

If placement in the out-of-state facility is approved, the Prior Approval Unit shall, within 3 working days of the receipt of the request, forward copies of the approval and of the permission for placement to:

- A. The WSO/CSAO/LTCEU responsible for the recipient's case. The WSO/CSAO/LTCEU must retain the copies of the approval and of the permission for placement in the recipient's file; and
- B. The specified out-of-state long-term-care facility. The facility must retain the copies of the approval and of the permission for placement in the recipient's record.

Criteria for Approval for Placement

The Prior Approval Unit will grant approval for out-of-state placement when the specified facility is approved as a Massachusetts Medical Assistance Provider, and one of the following conditions exists:

- A. a recipient who is temporarily outside of Massachusetts is in immediate need of skilled nursing or intermediate care facility services and the circumstances are such that the recipient's return to the Commonwealth would adversely affect the recipient's health;
- B. a recipient is in need of special medical, nursing or therapeutic services which are not provided by skilled nursing or intermediate care facilities within the Commonwealth. Under these circumstances, the Medical Division will approve placement in the appropriate out-of-state facility which is closest to the recipient's residence;

3123 (con't)

- C. a recipient in need of long-term care services is a patient in an acute hospital and the following conditions are met.
1. The area within 25 miles of the residence of the recipient or his family is underbedded for the recipient's documented level of need according to the bed planning targets most recently approved by the Public Health Council for the specific long-term care.
  2. Repeated unsuccessful efforts to place the recipient within 25 miles of the residence of the recipient or his or her family have been documented by the hospital, including the reasons for refusal.
  3. Placement in an out-of-state facility in a community bordering Massachusetts is in the recipient's best interest.
  4. The recipient is a resident of a locality which regularly uses medical resources in bordering communities and the specified long-term care facility is closer to the recipient's residence than the nearest in-state facility in which appropriate institutional services are available.

3124: Criteria For Denial of Continued Placement

When the Prior Approval Unit determines that the condition which required that the recipient be placed in an out-of-state long-term care facility no longer exists, the Prior Approval Unit will notify both the recipient and the facility and request that the recipient transfer to an appropriate facility in Massachusetts.

Unless the Prior Approval Unit receives acceptable documentation from the facility and the recipient's attending physician that the recipient's return to the Commonwealth would adversely affect his or her health, failure of the recipient to transfer shall be viewed by the Department as an indication that the recipient intends to reside in the other state. The recipient must then be notified that he is no longer eligible to participate in the Massachusetts Medical Assistance Program. The notice must include an explanation of the recipient's right to a fair hearing and the appropriate appeals procedures.

3125: Patients Under 21 in ICF MR's

Patients under 21 in Intermediate Care Facilities for the Mentally Retarded (ICF-MR) are residents for Medical Assistance purposes, as long as their placement in the ICF-MR was made by a parent or guardian who was a resident of the State at the time of placement.



3126: Foster Children

A child who is in the custody of the Department of Social Services (DSS) meets the residence requirement for MA. If the foster family moves out of state but continues to be assisted by DSS, the child continues to be a resident of Massachusetts for MA purposes.

3130: Individuals in Penal Institutions

Inmates in penal institutions are not eligible for Medical Assistance. Inmate status is not interrupted by a transfer to a public or private medical or mental institution. Halfway houses are not considered penal institutions.

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## 3140: Individuals in Institutions for Mental Disease

Persons under the age of 21 or age 65 or older who are patients in a public or private institution for mental diseases meet the residency requirement. An individual who attains the age of 21 while a patient in an institution for mental diseases may be eligible for Medical Assistance until he or she attains the age of 22, provided he or she meets the categorical requirements of the MA/DA program.

An individual who enters an acute hospital from an institution for mental disease meets the residency requirement as long as he or she is an inpatient of the hospital.



3150 Summary of Residency Requirements

The following persons are residents of the Commonwealth for purposes of eligibility for Medical Assistance if the following conditions are met.

SUMMARY TABLE RESIDENTS

	Other Requirements
Homeless Persons	Alternative verification of establishment of residence (see 503.100)
Migrant Workers	Entered Massachusetts for employment purposes
Persons Temporarily Absent	After 30 days, acceptable reason for absence
Former Recipients of Assistance in Another State	Termination of assistance
Persons Placed in Institutions Out-of-State	Placement made by public agency, or age under 21, or incapability of stating intent
Persons in Institutions in Massachusetts	Placement approved by Department, or placement is ICF-MR, or age 65 or older and in public or private institution for mental disease or age 21 or younger (or in some cases up to age 22 - see 3140) in public or private institution for mental disease.
Foster Children (except Title IV E)	Placed by Massachusetts with an in-state family or with a family that moves out-of-state
Foster Children (Title IV E)	Placed by another state with a family that moves to Massachusetts

Summary Table, Non-Residents

Persons who are not residents for Medical Assistance purposes regardless of their residence in the Commonwealth and intent to reside are:

- A. persons placed in institutions in Massachusetts by another state;
- B. persons under 21 placed in institutions in Massachusetts by a parent or guardian who resides in another state;
- C. persons who after attaining the age of 21 became incapable of stating intent to reside in a state other than Massachusetts;
- D. persons under 65 in a public or private institution for tuberculosis;
- E. persons age 22 to 65 in a public or private institution for mental diseases; and
- F. persons in penal institutions.



3200: Citizenship and Alienage

To be eligible for Medical Assistance, an applicant or recipient must be one of the following:

ELIGIBILITY REQUIREMENTS	HOW TO VERIFY (Policy Manual Reference)
Citizen of the United States	503.200B
Individual lawfully admitted to the U.S. for temporary or permanent residence	503.200(C)
Individual permanently residing in the U.S. under color of law	503.200(C)
American Indian born in Canada	503.210

A child who meets any of these conditions may be eligible for Medical Assistance even though one or more of his relatives does not. A parent or legal guardian who is ineligible for Medical Assistance because of his alien status may be the grantee-relative for those children who do meet the citizenship requirement.

Aliens unlawfully residing in the United States or its territories may be eligible for emergency medical services (see 7750).

Aliens lawfully admitted for a temporary purpose, such as students, visitors, and diplomats, are not eligible for Medical Assistance.

3201: Citizenship and Alien Status Verification

A list of acceptable verifications for citizenship and alien status may be found in 106 CMR 503.200.

3205: Aliens Lawfully Admitted as Refugees

MA workers must review all applications by aliens to determine if the applicant is eligible for the Refugee Resettlement Program (RRP). If the entrant status on the applicant's immigration document identifies him as a refugee, and if the date of application is not more than 12 months after his date of entry into the United States, the refugee may be eligible for RRP. Since the RRP is funded by the federal government, it is important that all eligible recipients be approved under this program. Applicants or recipients of RRP are assigned to seven designated Welfare offices that have bilingual workers - Attleboro, Boston (Hamilton Place), Chelsea, Lowell, Lynn, Springfield, and Worcester. Workers should refer to Section 4800 for the requirements of the Refugee Resettlement Program and referral procedures.



3300: UTILIZATION OF POTENTIAL BENEFITS

Both applicants and recipients are required to develop and utilize resources that may be available to them.

This section describes the most common resources, their basic eligibility requirements, and the agencies that administer them. Not all applicants and recipients who meet the basic requirements described herein will actually be eligible. However, if it appears that an individual meets the eligibility requirements, he must apply for the resource.

Medical Assistance may be provided until benefits are actually received, at which time the financial eligibility of the assistance unit will be reassessed. Potentially available resources must be utilized at any time they become available or when the worker becomes aware of their potential availability. Recipients as well as applicants must apply for potential resources, including any health plan that is free.

3301: Potential Health Insurance Coverage

Since Medicaid is the payor of last resort, all potential health insurance coverage available without cost to the applicant or recipient must be pursued and utilized. Many applicants have health coverage through their employer, while others may be covered through health plans maintained by an absent parent or former spouse.

Applicants and recipients must supply information regarding all health insurance coverage available to them. The existence of health insurance through an absent parent can be documented by court records, divorce or separation decrees, or by contacting the former spouse's employer (without divulging the name of the employee). (See 3300)

3302: Retirement, Survivor and Disability Insurance (RSDI)

RSDI benefits, known generally as "Social Security" benefits are paid under a social insurance program administered by the Social Security Administration. All individuals must have a certain insured status before RSDI benefits can be paid to the person or his family. A person is insured if he has worked a sufficient amount of time during which he paid FICA or Social Security tax. The number of quarters needed varies; however, a minimum of six is required. Nine out of ten workers in the country are insured under the RSDI program.



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Monthly RDSI benefits can be paid to:

- A. a disabled insured worker under 65;
- B. a retired insured worker 62 or over;
- C. a spouse of an insured retired or disabled worker, who is over 62, or in the case of a wife, has the care of the worker's child(ren) under age 16;\*
- D. the divorced wife over age 62 married at least 10 years to an insured retired or disabled worker;
- E. the surviving spouse (including a surviving divorced wife) of a deceased insured worker when such spouse is 60 or over;
- F. the dependent, unmarried child of an insured retired, disabled or deceased worker, when such a child is under 18, or under 19 and attending secondary school, or 16\* or over but suffering a disability which began before (s)he reached age 18;
- G. the disabled surviving spouse (including a surviving divorced wife) of a deceased insured worker, when such disabled spouse is 50 or over;
- H. surviving spouse (including a surviving divorced wife) of a deceased worker when such spouse is caring for a child under age 16;\*
- I. individuals who reached age 72 before 1972 and are not insured for standard benefits. This entitlement is commonly referred to as the "Prouty" benefit; and,
- J. a dependent parent over age 62 of a deceased worker.

\* The ages stated in these sections became effective 9/1/81. Under the old law benefits were paid to a mother or father caring for a child receiving benefits as a dependent child of a retired, disabled or deceased worker until the child reached 18. Parents who were already getting these benefits by August, 1981 will continue to get benefits until the child reaches 18 or through August 1983, whichever comes first.

The new law will gradually phase out benefits to students attending college or post-secondary school. Benefits will continue for an unmarried student who was entitled to a check for August, 1981 and was a full-time student 18-22 at a college or other approved post-secondary school before May 1982.



Application for RSDI benefits can be made at the local Social Security Administration Office serving the area in which the applicant or recipient resides.

If there is any indication that the applicant or recipient might be eligible for RSDI in his own right or as a dependent, he must apply for these benefits at the earliest age of entitlement. Application for or receipt of these benefits may be verified by request on Form SSA-1610, "Request for Information by State Public Assistance Agency". This form is used for referral and exchange of information between the RSDI field office and the worker. Two copies of this form should be sent by mail to the local RSDI field office which serves the area in which the individual lives. A reply will be given to the worker by the RSDI field office giving the status of the case. If the reply indicates that no claim has been filed, the applicant or recipient is required to file a claim.

#### Recording of Medicare/Social Security Claim Account Number

When approving a case that has Social Security income, the worker must record the Social Security Claim Account Number in block 30 of the T.D.

Applicants/recipients who receive Social Security benefits and are covered by Medicare will have a Medicare Identification Number. Those receiving Social Security benefits but not eligible for Medicare will have a Social Security Claim Account Number. The number in either situation identifies the Social Security Account from which benefits are being paid. This number may be different from the applicant/recipient's own Social Security Number. The Medicare Identification Number and/or Claim Account Number may be obtained from the Medicare Card, SSA Award Letter or Social Security (green) check. (The numbers that appear on the SSI Award Letter or SSI (gold) check are the recipient's own number, while the ID or Claim Account Number may be that of a spouse or parent.

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The entire Claim Account Number shown, including the alpha or alpha/numeric suffix, must be placed in block 30 of the TD when adding a case to the RMF. This must also be checked for accuracy at redetermination or when updating the RMF.

The worker may conclude whose social security number is contained in the Social Security Claim Number by noting the alpha suffix. The suffix indicates whether the benefits are being paid based on the wage record and payment history of the recipient, the recipient's spouse, or the recipient's parent. (See appendix for a list of alpha suffixes and their meaning.) An example of this is illustrated by the Social Security Claim Number 210-45-9941C indicating that the individual is a dependent child. Therefore, the social security number, 210-45-9941, does not belong to the individual, but rather to one of his or her parents who is either deceased, disabled, or retired.

Sample of a Social Security Check

No. 22,283,086				
<b>PAY TO THE</b> <b>ORDER OF</b> <table border="1" style="margin: 0 auto; border-collapse: collapse;"> <tr> <td style="padding: 2px;">09</td> <td style="padding: 2px;">03</td> <td style="padding: 2px;">70</td> </tr> </table>	09	03	70	HARRY ROE FOR CHLRN 1641 THETFORD ROAD BALTO MD
09	03	70		
	210-45-9941 86 21204			
	<table border="1" style="margin: 0 auto; border-collapse: collapse;"> <tr> <td style="padding: 2px;">S: 1117</td> <td style="padding: 2px;">60</td> </tr> </table> C 500 SEC FOR AUG	S: 1117	60	
S: 1117	60			
<h2 style="margin: 0;">SPECIMEN</h2>				

Note that the "C" does not immediately follow the Social Security Claim Account Number directly but is to the right of and below the number.

3303: Unemployment Compensation

Unemployment Compensation is administered by the Division of Employment Security. Benefits are paid from funds created by a payroll tax on employers.

Most employees are covered by the program. An individual who has earned at least \$1200 in the 52-week period preceding his claim may be eligible unless he was discharged from the most recent job due to deliberate misconduct.

The Division of Employment Security determines the worker's eligibility by contacting previous employers. The worker must be currently available for work to receive Unemployment Compensation. Benefits can also be claimed from earnings in another state.

An application for Unemployment Compensation may be filed with the local Division of Employment Security.

3304: Worker's Compensation

The Worker's Disability Compensation Act of 1969 provides compensation for economic loss suffered by an injured worker and his family. Most workers in Massachusetts are covered under this Act.

Compensation is paid for injuries and illnesses which result from, or are related to, employment. Compensation is cash payment, vocational rehabilitation, and/or payment for medical care.

An individual with a work-related injury or illness may file a claim for compensation through his or her place of employment.

3305: State Retirement Benefits

Any retired State employee who has been employed for 20 years or has reached age 55 may be eligible. In addition, an individual who was employed by the State for longer than 6 months may be entitled to withdraw retirement benefits as a lump sum payment. Retirees receive annual cost-of-living increases effective July 1 of each year in which the Legislature passes an increase.

A retired State employee may apply for State retirement benefits at the State Retirement Board (Refer to Directory of Agencies Offering Benefits 3900).

3306: Railroad Retirement, Survivor, and Unemployment Insurance Benefits

Retirement, survivor, and unemployment benefits for railroad employees and members of their families are administered by the U.S. Railroad Retirement Board. Railroad employees include persons in related industries such as railroad labor unions and railroad car companies.

Retirement and survivor benefits are payable to:

- A. a retired worker with 10 years of creditable railroad service who is age 62 or older;
- B. a retired worker with 30 years of service who is age 60 or older;
- C. a disabled worker;
- D. the spouse of a retired worker receiving benefits; and
- E. the surviving spouse and children of a deceased worker who has at least 10 years of railroad service.

Application for benefits is made by contacting a Railroad Retirement Board district office in person, by telephone, or by mail. (Refer to "Directory of Agencies Offering Benefits 3900)

The Railroad Unemployment Insurance Act provides for two kinds of cash benefits: (1) unemployment benefits and (2) disability benefits. To file a claim for benefits, the unemployed worker should visit the nearest railroad unemployment claim agent's office.

Applications for disability benefits can be obtained from railroad employers, railroad labor organizations, or the Railroad Retirement Board.

3307: Federal Veterans Administration (VA) Benefits

Federal Veterans Administration benefits are frequently available to applicants and recipients of Medical Assistance, particularly those residing in nursing homes and chronic hospitals.

Applicants and recipients are required to apply for certain Federal VA benefits, if there exists the possibility of eligibility for these benefits. Federal VA benefits are distinguished from State Veterans Service Benefits (VSB), for which application is encouraged but not required.



- A. Basic Benefits. The basic Federal VA benefits which are available and for which application is required as a condition of MA eligibility are the following:
1. Compensation for Service Connected Disability. Veterans who are disabled by injury or disease incurred during or aggravated by active service may be eligible to receive a pension.
  2. Non-Service Connected Disability Pension. Veterans of war-time service with sufficient service time who become permanently and totally disabled for reasons not traceable to service may be eligible for a pension. Veterans over age 65 are considered disabled. There are, however, eligibility limitations on the amount of a claimant's resources.
  3. Dependency and Indemnity Compensation. Widows, widowers, children, and dependent parents of veterans who died from a service connected illness or injury may receive monthly benefits.
  4. Civilian Health and Medical Program of the Veterans Administration (CHAMPVA). The spouse (or surviving spouse) and children of a veteran with a service connected total disability may be eligible for such insurance. There is no premium for the insurance. A person entitled to Medicare is not entitled to CHAMPVA.
- B. Aid and Attendance Benefits. Persons in long term care may be eligible for the Aid and Attendance (A&A) benefit payment which is available to patients who need the level of care provided by an ICF or SNF (even though this care may sometimes be provided in the patient's home). Application for these benefits is mandatory if an individual is applying for MA.

All MA applicants or recipients who are eligible for Federal VA benefits and who are entering long-term-care facilities must be referred to the Office of the Commissioner of Veterans Services (OCVS). Make the referral by sending a copy of the MA/NFL 3I to the following address:

Office of Commissioner of Veterans Services  
· Leverett Saltonstall Bldg.  
Suite 1002  
100 Cambridge Street  
Boston, MA 02202

An agent of OCVS will follow up the referral by making a visit to the nursing home to assist the patient in applying for maximum VA benefits. Copies of VA award letters are sent to the Third Party Liability Unit (TPLU), who will then forward the information to the appropriate LTCU.

TPLU will review the award letters and identify that portion of the VA payment that is for A&A. This information will be forwarded to the LTCUs on a TPL Alert along with a copy of the award letter. Upon receipt of a TPL Alert (or any reliable source regarding an applicant's or recipient's receipt of A&A), you must complete an MA/NFL 3I. The portion of the VA payment that is specifically designated for A&A is not to be considered income and is to be separated from the total VA pension on the MA/NFL 3I; the A&A is not included in the Patient Paid Amount (PPA) nor is it to be counted in determining if this is an over/under case. The original of the MA/NFL 3I is sent to the client/representative, a copy in the case folder and copies are sent to the facility, TPLU and OCVS (if appropriate). If the amount of A&A changes, an updated MA/NFL 3I must be sent to the appropriate sources.

Many award letters will reflect retroactive VA benefits. TPLU will separate the basic portion of the retroactive check from that portion which was intended specifically for A&A. You should treat the basic portion of the retroactive check as a lump sum payment; the A&A portion of the retroactive check is also a third party resource and will be recovered by Central Office.

NOTE: A nursing home may never bill Medicaid more than the public rate. If a patient's combined PPA and A&A exceed the public rate, the nursing home must apply the A&A to the bill (at the public rate) before applying the PPA to the remainder of the bill. The nursing home must then return the portion of the PPA which exceeds the bill to the patient. You should be aware that this excess amount is a countable asset that will be available every month and will subsequently increase the assets.

- C. VA Burial Expenses. For information regarding VA payments for burial expenses see 7120.
- D. Optional Benefits. The following benefits may also be available to some veterans and their dependents. This section is for information and referral purposes only. Application for these benefits is not required.

## 1. Veterans Administration Medical Care.

The VA provides hospital or outpatient care when needed for all service connected medical or compensable dental conditions. The treatment is given at a VA hospital or clinic, or, with prior approval, by a hometown physician or dentist. Hospital care can be provided on a bed-available basis for treatment of non-service connected conditions. Utilization of a VA hospital or clinic is not required because clients have freedom of choice of provider under the Medical Assistance Program.

## 2. Other VA Benefits.

- a. Educational Assistance (GI Bill).
- b. Special Adapted Housing for disabled veterans.
- c. Annual Clothing Allowance for veterans with prosthetic devices.
- d. Automobile or other conveyance purchase grants for veterans who lose a hand or foot, or have impaired vision in both eyes.
- e. Domiciliary Care in a VA facility.
- f. Substance abuse treatment.

3308: Other Pensions

Sick pay, pension benefits, supplemental unemployment benefits, and annuities may be available to an applicant or recipient or member of the assistance unit from an employer, union, or private insurance agency. Such funds are likely to be available to workers who are ill, unemployed, retired, or approaching retirement.

These benefits may be applied for through the employer or other appropriate sources.





3310: Identifying Health Coverage

Workers should be aware that applicants may be entitled to medical coverage from many sources through retirement plans, employment, private enrollment, or plans maintained by a relative. Workers must complete a Third Party Liability (TPL) Supplement (F3311B) for each type of health insurance available to an assistance unit except Medicare. The TPL Supplement is sent to the Third Party Recovery Unit (TPRU), and a copy is held in the case record. The TPRU investigates the type and scope of health care coverage available to recipients from information on this form. The following list contains examples of some of the more common coverages which should be explored.

A. Elderly or Disabled Persons

Medicare (see section 3320).

Medex-O.M.E.

Blue Cross/Blue Shield offers a Medicare Supplemental policy (MEDEX) for individuals age 65 and over (see 3321). Aetna offers an Optional Medicare Extension (OME). Other companies offer similar plans. Premiums are usually paid quarterly.

B. Federal Employees

Former federal employees who are receiving Civil Service Annuities may have Blue Cross/Blue Shield or other health insurance premiums deducted automatically from their monthly benefit checks. If they start receiving Medicare, the BC/BS policy is automatically reduced to the Medicare Supplemental policy.

C. Families of Military Service Personnel

Spouses and dependents of active, retired, deceased, or totally disabled military service personnel may have medical coverage through CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) or CHAMPVA (Civilian Health and Medical Program of the Veterans Administration).

D. Union Members

Union members often participate in group health plans. These may carry over during periods of unemployment at the company's and/or employee's expense.

E. Students

Students often purchase inexpensive medical insurance through their school or college, or may be covered by their parent's insurance. Some colleges require that students purchase this insurance as part of the enrollment fee.

F. Divorced or Separated Parents

A court order often requires a parent to maintain health insurance coverage for his/her children and for the spouse until the divorce is final.

G. Step-Parents

Step-parents often carry health insurance coverage which includes their step-children.

3311: Third Party Liability (TPL) File

The MMIS Third Party Liability (TPL) File contains detailed information about the specific types of health care coverage available to recipients - the policy numbers, and the services available through each health insurance plan. The basic information must be recorded on a TPL Supplement and submitted to the Third Party Recovery Unit (TPRU) as well as entered in blocks 31 and/or 64 of the TD. TPL Specialists in the TPRU verify and expand this information and enter it on the MMIS TPL File. This information is used by MMIS to edit provider claims for medical services.

A. TPL Supplement

A TPL Supplement must be completed for every case at application. The TPL Supplement is used to inform the TPRU of health care coverage reported by applicants and recipients, as well as to identify cases with potential third party coverage (see 3310). A TPL Specialist will then verify and expand this information and enter it on the MMIS TPL file.

At redetermination, if a case contains a TPL Supplement, a new supplement need be completed only when information has changed. (You should access the MMIS TPL screen for current health insurance status.) If information remains the same, initial and date the form in the top right hand corner.

You must complete a TPL Supplement in the following instances:

1. at application for a new or reopened case;
2. at redetermination if no TPL Supplement is contained in the case record or when one of the factors, listed in 3 below, has changed;
3. as a case maintenance activity whenever there is a change in one of the following factors listed on the TPL Supplement:
  - ° health insurance
  - ° absent parent status
  - ° stepparent living with family
  - ° employer
  - ° military status of a family member

(You need complete only Section I and those items that have changed.)

A TPL Supplement must be completed and submitted to the TPRU for each type of health care coverage except for Medicare that is available to an assistance unit. If more than one type of coverage is available, you must complete Sections I and II of the Supplement for each additional policy. Copies of the Supplement(s) should be stapled together and filed next to the most recent redetermination or application form.

B. TPL Alert

When you discover that a TPL resource is no longer in effect, update FMCS by changing the health insurance code in blocks 31 and/or 64 to reflect no insurance or only the remaining health insurance. At the same time complete a TPL Alert and give the original to the supervisor with the TD. If the TPL Specialist agrees that the resource no longer exists, there will be no further correspondence.

If, after investigation, the TPL Specialist finds that the resource is still available, he or she will contact the MMIS Coordinator to request that FMCS be corrected.

TPL Alerts and TPL Supplements that indicate changes requiring a TD are submitted with the TD for transmission to the MMIS Coordinator. Whenever either form is completed for a change that does not require a TD, give the original directly to the MMIS Coordinator and file a copy in the case record next to the most recent application or redetermination.

C. TPL #1

When investigation by the TPRU results in the discovery of a health care resource that was previously unknown, the TPRU sends a TPL #1 to the recipient. The TPL #1 informs the recipient of the health care coverage available to him or her.



3320: Medicare

Medicare is the federal health insurance program for the aged, blind, and disabled. It consists of two parts: Part A, hospital insurance, and Part B, medical insurance. The Social Security Administration and the Health Care Financing Administration (HCFA) are responsible for administering the Medicare program.

Any eligible family member entitled to Part A Medicare coverage without charge is required to enroll for Part A as a condition of Medical Assistance eligibility. This requirement is considered met once the individual has applied for enrollment, even though SSA may not have processed the application. Since Part A coverage may be granted retroactively up to 12 months (if all eligibility requirements were met), this condition of eligibility must also be met by applicants for retroactive Medical Assistance.

If an eligible family member is purchasing Part B coverage, MA will not pay for services that are covered by Part B. Applicants and recipients should be urged to enroll, but enrollment in Part B is not a requirement for MA eligibility.

Part A: Hospital Insurance. A person will usually be eligible for Medicare Part A if he meets the following requirements:

- A. is age 65 or older and insured or the spouse of an insured worker; or
- B. has been entitled to RSDI disability or Railroad Retirement disability benefits for 24 consecutive months; or
- C. is insured under the Social Security or Railroad Retirement system and requires dialysis treatment or a kidney transplant because of permanent kidney failure. The spouse or child of an insured worker may also be eligible for dialysis or a transplant under Medicare.

Persons receiving RSDI benefits are automatically enrolled in Part A when they become eligible. Other persons must make application for coverage at their local SSA office. Coverage can be retroactive up to 12 months. Persons may apply as much as 3 months prior to their sixty-fifth birthday. Application may be made on behalf of a deceased person.

Most people do not pay a premium for Part A. Only persons with insufficient work quarters under the Social Security program pay a monthly premium for Part A.

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Part B. Medical Insurance. Another name for Part B Medicare is Supplemental Medical Insurance Benefits (SMIB). A person will usually be eligible for Part B Medicare if:

- A. he is entitled to Medicare Part A, hospital insurance; or
- B. he is not eligible for Medicare Part A but is at least age 65, is a resident of the United States, and is either:
  - 1. a U.S. citizen; or
  - 2. an alien, lawfully admitted for permanent residence, who has resided in the U.S. continuously during the 5 years immediately preceding the month in which (s)he applies for enrollment.

Persons who become entitled for Part A hospital insurance are automatically enrolled in Part B unless they specifically refuse Part B coverage. The initial enrollment period is a period of seven calendar months; i.e., the month the person's eligibility begins and the three months before and the three months after that month. Persons who refuse automatic enrollment or miss the initial enrollment period may enroll during the annual "general enrollment period" of January 1 through March 31.

All enrollees in Part B, Medicare pay a monthly premium; the amount of the premium is determined by the U.S. Department of Health and Human Services. Persons enrolling when first eligible pay the standard premium. Persons enrolling later pay a higher premium. The premium amount is increased by 10 percent for each 12 months that the person could have been but was not enrolled. Premiums are collected from RSDI and Railroad Retirement beneficiaries by deducting the monthly amount from their benefit check. Other individuals are billed by mail quarterly.

SSI recipients who are aged or have been disabled 24 months are eligible for Part B and the State pays the premium. A recipient who is eligible for MA by virtue of the Pickle Amendment continues to have his Part B premium paid by the State. Workers must be careful not to allow a Part B premium deduction for Pickle-related cases.

Medicare Card. Persons enrolled in Medicare receive a red-white-blue Medicare health insurance card. The card shows the type of coverage the individual has (hospital insurance, medical insurance, or both) and the Medicare Identification Number.



N.B. The Medicare Identification Number which appears on the card is the Social Security Claim Account Number for the recipient. It may or may not be the same as the recipient's Social Security number. (See 3302.) The worker must enter this number and the alpha-numeric suffix in the appropriate block of the T.D. (See 3330.)



3321: Medex (Medicare Extension) Coverage

Medex is a program administered by Blue Cross/Blue Shield to supplement Medicare. A person is eligible for Medex if he is 65 years of age or older and covered by both Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare or if he is under 65 and is covered by Medicare Parts A and B due to a disability.

There are four types of coverage available under Medex, ranging from the minimum coverage of the Low Option to the maximum coverage of Medex III.

Eligible persons may subscribe to a Medex individual plan or may be enrolled in a group plan that is paid in part or totally by a former employer. While the Department encourages enrollment in Medex, no applicant/recipient can be required to maintain Medex coverage unless it is offered free of charge through a retirement plan.

Medex Individual Plans

When a recipient has an individual Medex plan, Medex premiums are paid quarterly for the coming quarter. Each year Blue Cross/Blue Shield requests a rate increase for each Medex option. If the rate increase is approved, the patient paid amount for recipients with individual Medex coverage in long-term-care facilities will be automatically updated provided the correct code appears in block 31 of the TD. (See below.)

Medex Group Plans

Some persons are covered by Medex as the result of a pension plan that includes Medex coverage. These persons are usually retired from state or municipal government positions or from private companies. The employer contracts with Blue Cross/Blue Shield for a particular Medex option plan and also contracts for a rate, which is usually lower than the individual plan rates. The cost to the retiree for the Medex group plan is determined by the former employer and is usually deducted from the pension check by the employer. It ranges from zero to a percentage of the actual cost. Medex rates for group plans change when the contract with Blue Cross/Blue Shield is renegotiated, (not necessarily at the same time as the rate change for individual plans).

## MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

3321

To enable the system to update long-term-care cases with individual Medex, workers must distinguish between individual and group Medex plans by coding block 31 of the TD with one of the following:

<u>Health Insurance</u>	<u>Individual Non-Group</u>	<u>Group Coverage</u>
Medicare A&B Plus Medex 1	F1	F6
" " " " 2	F2	F7
" " " " 3	F3	F8
" " " " Standard*	F4	F9

NOTE: The F5 code is used to indicate the presence of Medicare A & B and a supplemental health insurance other than Medex.

---

\* Known as Medex Low Option until December, 1983.

T3322: SSI Recipients - Health Insurance Questionnaire

On October 12, 1982, a mass mailing was made to SSI recipients who had been identified by SSA records as having Medicare coverage. Recipients were asked to complete a questionnaire which would provide the Department with information regarding any additional health insurance coverage which they held. As a result of that mailing, the Third Party Recovery Unit received responses resulting in over 5,000 adjustments in the coding of SSI recipients' health care coverage.

The results of that mailing have been forwarded to the Medical Claims Control Center in Westboro which will begin updating the Recipient Master File the week of December 20, 1982. This update will generate a revised Turnaround Document for each SSI recipient whose response to the mailing resulted in a valid change in his coded health care coverage.

Upon receipt of the updated Turnaround Documents (run date 12/20/82 or later) workers should destroy all obsolete T.D.'s contained in the case record and use only the new T.D.'s with the updated health insurance information. Medicaid cards received by recipients subsequent to the Westboro update will also reflect the updated health insurance coverage.

Workers should not change the health insurance code on the updated T.D. or issue an MA-ID-2 with different information than that on the updated T.D. without first contacting the Third Party Recovery Unit (TPRU). If the SSI recipient disputes the health insurance coverage indicated on the Medicaid eligibility card, the worker should contact the TPRU at 227-8320 X309 or 310. That unit will pull the questionnaire submitted by the recipient and contact the private insurance carrier to determine if the recipient's health insurance coverage is still in effect. Depending on the insurer's response, the worker will then be advised by the TPRU to change the coding on the Turnaround Document or to advise the SSI recipient that his health insurance coverage is still in effect.





3330: Coding of Health Insurance Coverage

When the worker has approved a case, he must code block 31 (and 64 if applicable) with the correct code for the health insurance maintained by the individual and/or dependents.

The following is a list of health care coverage plans and the corresponding code that must be entered in block 31 and/or block 64 of the T.D. Block 31 contains health insurance information pertaining to the individual whose name appears in Section I of the T.D. Block(s) 64 contains information regarding the health insurance of each dependent.

BLOCK 31 & 64: HEALTH INSURERS, HMO(s) AND CASE MANAGEMENT PROGRAMSCODE DESCRIPTIONHealth Insurers

- A - Aetna
- B - Blue Cross/Blue Shield
- C - Medicare A+B
- D - Medicare A
- E - Medicare B

Medicare Supplemental Policies

- F1 Medicare A+B plus Medex 1
- F2 Medicare A+B plus Medex 2
- F3 Medicare A+B plus Medex 3
- F4 Medicare A+B plus Medex Low Option
- F5 Medicare A+B plus other

- J - John Hancock
- L - Liberty Mutual
- M - Metropolitan Life
- P - Prudential
- T - Travelers
- W - Health Care and Unions (Trade Unions)

CODE DESCRIPTIONMANAGED HEALTH PROGRAMSCase Management Programs

- Y - Beth Israel/Childrens
- . - Uphams Corner Health Center
- . - South End Family Health Center
- . - Roxbury Comprehensive
- . - Mass. Dental Project
- . - Mass. Dental Project and South End F.H.C.

HMO(s)

- G - Boston Health Plan
- H - Harvard Community Health Plan
- S - Fallon HMO
- V - Valley HMO

Other/None

- O - Other
- Z - None

Managed Health Programs

All codes for Case Management Programs and Health Maintenance Organizations are entered by the Case Management Unit at Central Office. Workers should not take any action to change these codes on T.D.s. The Case Management Unit will send lists of changes in enrollment, on a monthly basis, to the local offices. At the present time these programs are available only to recipients of SSI, AFDC, and RRP (categories 0, 1, 2, and 3).

Recipients with private health insurance coverage (e.g., Blue Cross) are not eligible to enroll in Managed Health Programs. If a worker discovers that a grantee or dependent has private health insurance and is also enrolled in a Managed Health Program, he should contact the Case Management Unit (426-4607).



3400: ASSIGNMENTS FOR THIRD PARTY RECOVERIES

The purpose of the Medical Assistance Program is to provide payment for medical care of persons who themselves cannot afford this care. According to federal and state law, MA must be the payer of last resort. Any medical expenses for which a third party resource is potentially liable must be billed to the third party.

A third party is any individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant/recipient.

Insurance carriers are the primary source of third party recoveries. This includes hospital, medical, auto-accident, and general liability carriers.

All applicants/recipients of MA must be asked at application and at redetermination if they or anyone in their assistance unit have been involved in an accident or have had an illness or injury. This information may be secured from the application form and from verbal exchanges during the application/redetermination process. When an applicant requests Medical Assistance as a result of an injury or disability, or when a recipient has been involved in an accident, the worker must take an assignment if there is even a remote possibility of third party payment.

Information regarding an accident involving a recipient may be brought to the worker's attention by the recipient, by the hospital or other medical facility treating the recipient, or sometimes by other divisions within the Department. Because the Department may at any time begin paying for unreported events of this kind, it is important to inquire into this matter whenever a potential recovery situation comes to the worker's attention.

The Department shall determine whether an applicant/recipient has good cause for refusing to cooperate in accordance with 106 CMR 303.730 through 303.735 if filing a claim is believed to be against the best interests of the applicant/recipient. An applicant/recipient need not file for third party compensation if the Department determines that the applicant/recipient has good cause for refusing to cooperate.

The types of accidents and illnesses that are most likely to involve a third party liability for medical or maintenance expenses are the following:

- A. job-related accidents or illnesses (employer may be liable, or Worker's Compensation coverage may be available);
- B. automobile accidents (driver(s) of other car or cars, their insurance carrier(s) or recipient's insurance carriers may be liable);
- C. home accidents (landlord or insurance carrier may be liable);

- D. accidents on public property (city, town, state, etc. may be liable);
- E. poolside accidents (homeowner may be liable);
- F. violent crimes in which the applicant/recipient is the victim (Commonwealth may be liable); and
- G. medical malpractice cases (physician, hospital, or other provider may be liable).

3401: ASSIGNMENT FORMS

When it is determined that a third party is potentially liable, the worker must inform the client of his or her obligation to reimburse the Department for medical payments made on his or her behalf if and when the settlement with the third party is made. An assignment must be taken on any case in which there is a possibility of future payment.

The client is required to complete an Assignment of Third Party Recovery, A-16, and to file a claim for any potential available compensation. The A-16 is an NCRd form consisting of an original and two copies. The A-16 must be completed by the worker and signed by the client. If the client is physically unable to sign the A-16, his authorized representative who has been appointed guardian or conservator by a probate court must sign for the client.

After the A-16 is signed, the worker must also complete the Assignment Information Sheet, the A-17. The A-17 is an NCRd form consisting of an original and one copy. It is important that all questions on this sheet be accurately and completely answered.

After all necessary information has been obtained and both forms are appropriately completed, the worker sends the originals of the A-16 and A-17 to the:

Assignment Collection Unit  
P.O. Box 86  
Essex Station  
Boston, MA 02112

The first copy of the A-16 is to be given to the client. The second copy of the A-16 and the copy of the A-17 is to be filed in the case record.

The Assignment Collection Unit (ACU) at Central Office receives information via the MMIS billing system on clients receiving trauma treatment. The ACU files are checked to assure that an A-16 and A-17 are on file. However, if the appropriate liens are not on file, the local office will be contacted and notified that the ACU staff will either obtain the A-16 and A-17 or instruct the worker to obtain them.

The Assignment Collection Unit is responsible for determining the amount of the payment to the Department and for collecting this amount. After a case has been settled, the ACU sends copies of the assignment discharge and an accounting statement to the client's attorney and to the local office. The worker must take action to close the case if necessary.

All questions, including the client's questions concerning third party liability or assignments are to be directed to the Assignment Collection Unit.





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F3401C

F3401 C: A-18MA Cover Letter for Hospital Referral of Potential Assignment  
Collection Case



*The Commonwealth of Massachusetts*  
*Executive Office of Human Services*  
*Department of Public Welfare*

OFFICE OF FINANCE - ASSIGNMENT COLLECTION UNIT

FIFTH FLOOR, TEL. # (617) 727-0660

DATE: \_\_\_\_\_

TO:

FROM:

RE: HOSPITAL REFERRAL OF POTENTIAL ASSIGNMENT COLLECTION CASE

Recipient's  
Name \_\_\_\_\_

Recipient  
ID \_\_\_\_\_

The attached referral indicates that a recipient has been treated for an injury as a result of an accident for which a third party may be liable. We do not have an A-16 Assignment Form or A-17 Assignment Information sheet on file.

Please determine if the A-16 and A-17 forms have already been completed. If they have, copies should be distributed in accordance with instructions. If no A-16 or A-17 has been secured, contact the recipient for completion of the form. See 3401 of the MA Handbook for instructions on completion.

Please provide the information requested on the reverse side of this form, attach it to the completed A-16 and A-17 if applicable, and return them to the Assignment Collection Unit within 30 days of the date of this letter. Note that failure of the recipient to cooperate in the completion of the assignment form may be grounds for termination of assistance in accordance with 106 CMR: 503.400.

A-18MA

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F3401D: A-18MA (Reverse) Response to Request for Information from ACU

COMMONWEALTH OF MASSACHUSETTS  
DEPARTMENT OF PUBLIC WELFARE

DATE:

TO: Assignment Specialist, A.C.U.

FROM:

RE: Referral

-----

☐ A-16/A-17 Attached

☐ Case Closed

☐ Other \_\_\_\_\_  
(explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Financial Assistance Worker

\_\_\_\_\_  
Date

A-18MA (Reverse)

3410: Assignment of Rights to Medical Support

As a condition of eligibility, all applicants/recipients must assign to the Department their rights to medical support and any third party payments for medical care, as well as the rights of any other eligible individual for whom he or she can legally make an assignment (e.g., a parent for a child). A mentally or physically incompetent applicant/recipient with no legal representative is not required to make this assignment. Mental or physical incompetency must be verified and filed in the case record.

Medical support is defined as support for the purpose of medical care by a court or administrative order. Medical support may be ordered by a court; however, an absent parent may voluntarily agree to provide medical support. "Assignment of Medical Support" means that the applicant/recipient is actually assigning to the Department rights to third party medical coverage or reimbursement from a third party for medical benefits. When the applicant/recipient assigns rights to medical support, the Department can then pursue any potential third party medical coverage, thereby ensuring that Medicaid is the payer of last resort. The assignment of rights does not affect reimbursement for medical services that are not provided for under the Medical Assistance Program.

The situation in which an applicant/recipient must assign rights to medical support will most frequently arise in MA/AFDC and MA/21 cases with an absent parent. In these cases, the applicant/recipient must be advised that absent parents may have health insurance coverage for the child(ren) available at little or no cost. The applicant/recipient should be informed that assignment of these rights will not affect his or her independent right to seek medical support or any other support in any court proceeding.

Each applicant/recipient who assigns his or her rights to the Department must cooperate with the Department in obtaining medical support or payments unless good cause for refusing to cooperate is determined to exist (see 106 CMR 303.730 through 303.735). The Department will not attempt to obtain medical support pursuant to an assignment by an applicant/recipient for whom good cause for refusing to cooperate has been determined, unless the Department also determines that such an attempt can proceed without risk of harm to the applicant/recipient or his or her children if the attempt does not involve his or her participation.

The applicant/recipient makes an assignment of rights by signing the A34/36, which makes him or her aware that the Department will pursue third party coverage. Because it must be demonstrated that the applicant/recipient understands that, by signing this form he or she is assigning his or her rights to medical support, a verbal explanation by the worker may be necessary. If a face-to-face interview is necessary, the worker must witness the applicant/recipient's signing and sign the form where indicated. Signatures of applicants must be obtained at application and signatures of recipients must be obtained at the next redetermination.

(The A-34/36 must be completed regardless of whether there is a TPL supplement or a TPLA in the case record.) A copy of the form is kept in the case record and a copy given to the applicant. For MAOA cases, the recipient is not required to sign another A-34/36 if there is a signed A-34/36 in the AFDC case record. The A-34/36 must be signed if the MA case closes and the former recipient reapplies.

3420: Cooperation In Establishing Paternity and Obtaining Medical Support

Each applicant or recipient must cooperate with the Department in obtaining medical care support and payments for a child for whom MA is requested.

Cooperation with the Department includes taking any reasonable steps to assist in establishing paternity and obtaining medical care support. Each applicant or recipient must cooperate unless the Department determines that the applicant or recipient has good cause for refusing to cooperate. If it appears that the applicant or recipient has good cause for refusing to cooperate, the worker must assist in determining good cause in accordance with 106 CMR 303.720 - 303.735 of the AFDC Policy Manual. If the applicant or recipient fails to cooperate with the Department without good cause, he or she is then ineligible for Medical Assistance. He or she may be the ineligible grantee relative for any children who are eligible and the case should be coded appropriately.

NOTE: A case that contains a pregnant woman who is otherwise eligible for MA and is terminated or denied Medical Assistance because of failure to cooperate in signing the form should be referred to the Healthy Start Program. This is not a requirement for presumptive eligibility.

3430: Collecting and Forwarding Information on Absent Parents

Federal regulations require that information on absent parents be obtained and forwarded to the Child Support Enforcement Unit (CSEU) at the Department of Revenue (DOR). The MA-CA/CS form must be completed at application, at redetermination (if one has not been completed), or if there is a change in the absent parent's circumstances.

The MA-CA/CS must be completed for each case in which there is a dependent under 18 whose parent(s) is absent from the household. A separate form must be completed for each absent parent in the case (unless the deprivation factor is death). If the grantee refuses to complete the form without good cause, he or she is ineligible for MA. When the form has been completed, send the original to CSEU, a copy to TPLU and file a copy in the case record. Also, you must send the original of the A-34/36 to CSEU and keep a copy in the case folder.

NOTE: If a pregnant woman is applying only for herself, an MA-CA/CS does not have to be completed until the redetermination following the child's birth.



3430 (cont.)

A new MA-CA/CS does not have to be completed for MAOA cases if there has already been an obligation established for the absent parent(s) by CSEU, unless there has been a change in circumstances. To find out if an obligation has been made, you must access the inquiry screen on the Child Support Tracking System (CSTS). (See CM-88-20 for information about accessing CSTS). Information is available on that screen for the (former) AFDC case. If there is an obligation, but the recipient informs you that there has been a change in the absent parent's circumstances, print the screen, have the recipient complete an MA-CA/CS with the change, send the original of the form and a copy of the screen to CSEU, a copy of the MA-CA/CS to TPLU and keep copies of each in the case folder.





3900: Directory of Agencies Offering Benefits

Federal Veterans Administration  
JFK Bldg. Government Center  
Boston, MA (800-392-6015)

Massachusetts Retirement Board  
One Ashburton Place  
Boston, MA 617-727-2950  
800-392-6014

Railroad Retirement Board  
1802 Post Office Bldg.  
Boston, MA 617-223-6542

U.S. Government Office of Personnel Management  
Retirement and Insurance Programs  
1900 E. Street N.W.  
Washington D.C. 20415



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## CHAPTER FOUR - CATEGORICAL REQUIREMENTS

4000 - OVERVIEW OF CATEGORICAL REQUIREMENTS

All individuals who receive medical assistance are divided into two groups known as the categorically needy and the medically needy. The categorically needy are those who receive cash assistance under a federally funded category; they thereby receive medical coverage automatically without having to file a separate application unless they need assistance in paying medical bills incurred prior to the date of application. The medically needy request, or are eligible for, assistance with their medical bills only; they receive no cash.

With a few exceptions described in the appropriate sections of this chapter, medically needy persons must meet the same categorical requirements as recipients of the cash assistance programs. In Massachusetts, Medical Assistance services for the medically needy and the categorically needy are the same.

Sections 4100 through 4499 describe the procedures for determining whether families or individuals meet the categorical requirements for the AFDC-related categories of medical assistance, e.g., MA/AFDC and MA/21.

Sections 4500-4999 describe the procedures for determining whether individuals meet the categorical requirements for the SSI-related categories, e.g. MA/DA and MA/OAA.



4100: AFDC-Related ProgramsAFDC and RRP

Current recipients of AFDC and RRP cash assistance as well as families and individuals deemed to be receiving AFDC or RRP are categorically needy recipients of medical assistance.

Individuals and families deemed to be in receipt of AFDC or RRP include:

- . recipients whose monthly AFDC payment would be less than \$10.00;
- . children receiving adoption assistance or foster care maintenance; and
- . assistance units that receive an automatic extension of medical benefits upon termination from cash assistance.

MA/AFDC

MA/AFDC provides medical assistance for both the grantee-relative and the child(ren) under the age of 21, when the child is deprived of the care or support of the natural or adoptive parent(s). In such cases, the filing and assistance units are the same. MA/AFDC also provides medical assistance to any pregnant woman who meets the basic and financial eligibility requirements. Her spouse, if present in the home, must be included in the filing unit but may not be included in the assistance unit unless he meets the categorical requirements. The unborn child(ren) is also included in the filing unit as if he had been born and was living with the family. Dependent children in the home may be included in the filing unit and assistance unit if including them is financially advantageous.

MA/21

MA/21, as its name implies, provides assistance only to those under the age of 21. In two-parent ("intact") families with no deprivation factor (see 4400), the parents or other grantee-relatives are not eligible for medical assistance for themselves unless they too are under the age of 21. Those having financial responsibility for the minor children under age 18 are included in the filing unit, but only those persons in the filing unit who are under 21 are included in the assistance unit.





4110: AFDC Program: Automatic Eligibility

Current recipients of AFDC as well as those deemed to be in receipt of AFDC receive medical assistance under AFDC (Category 2). The AFDC worker is responsible for all case maintenance activities necessary to provide MA benefits, such as verifying third-party health coverage, providing temporary MA-ID cards, verifying dates of eligibility for providers, and determining eligibility for three-month retroactive medical coverage when applicable.

4111: Refugee Resettlement Program: Automatic Eligibility

Current recipients of the AFDC or non AFDC components of the Refugee Resettlement Program are automatically eligible for Medical Assistance under RRP (Category 0). Refugees who choose not to apply for cash assistance, or whose income and/or assets exceed AFDC eligibility standards, may make separate application for Medical Assistance (see 4800).

4112: Extension of Medicaid Benefits Subsequent to Termination of AFDC Due to Increased Earnings

When an AFDC family or recipients of the AFDC component of the Refugee Resettlement Program have received assistance during three of the past six months, and the assistance is terminated because of increased income or increased hours of employment, the family continues to be eligible for medical assistance for the remainder of the month in which they became ineligible for AFDC or RRP and the following three calendar months, provided at least one member of the assistance unit continues to be employed.

EXAMPLE:

An AFDC case that opened on 11/15/83 closed on 3/24/84 due to increased earnings. Since the family had received AFDC for three of the six months prior to the closing date, they were eligible for the extended medical coverage. March was the first month of AFDC ineligibility. The extended medical eligibility period terminated June 30, 1984. An MA application is unnecessary until July.

4113 Extension of Medicaid Benefits Subsequent to Termination of AFDC Due to Loss of Earned Income Disregards

Effective 10/1/84, an AFDC family that becomes ineligible for cash assistance solely because either the one-third or the \$30 earned income disregard can no longer be applied to gross income will receive MA benefits automatically for nine months beginning with the month following termination of cash assistance.

4114 Extension of Medicaid Benefits Subsequent to Termination of AFDC/Receipt or Increase in Child Support Payments

An AFDC family that becomes ineligible for cash assistance as a result (wholly or partly) of the receipt or increase of spousal or child support payments will receive MA benefits automatically for four months beginning with the month the family becomes ineligible for AFDC.

This extension shall apply only to families becoming ineligible for AFDC before October 1, 1988.

4115 Responsibility for Cases with Extended MA Benefits

MA-ID cards are issued automatically by MMIS for the appropriate number of months after an AFDC or RRP case terminates for one of the above reasons. The Recipient Master File will show the case in closed status under AFDC or RRP (Category 0 or 2) but the case will remain open on MMIS, and the AFDC worker is responsible for all case maintenance activities during the extension.

Cases that remain open for only four months receive a notice informing them what their spenddown will be, if any, after the automatic extension. If these individuals contact the local office to present bills for services received after the extension, the MA worker will request the case record from the MAOA/Dever File and process the case according to regular spenddown procedures. The six-month period begins with the month after the end of the extension. If the calculation does not result in a spenddown the case will be "MAOA'd" in the third month.

Cases that remain open for nine months will be "MAOA'd" onto AFDC at the beginning of the eighth month of automatic MA. At that time the Centralized MAOA Unit will send the recipient an MA Redetermination Form and regular MAOA procedures will be followed.

4116: Title IV-E Subsidized Adoption and Foster Care Cases

The Department is responsible for providing Medicaid to children residing in Massachusetts who have been placed by another state in foster care or adoptive homes subsidized under Title IV-E. In addition, children receiving state subsidized adoption payments from a state which is a member of of the Interstate Compact on Adoption and Medical Assistance (ICAMA) will be eligible for Medical Assistance provided by the state in which the child resides if that state is also a member of ICAMA. Any child receiving state subsidized adoption payments from a state which is not a member of ICAMA or any child receiving state subsidized foster payments will only be eligible for Medical Assistance provided by their State of origin.

The respective states will notify a child's parent(s) and the Medicaid Division at Central Office of the children who are eligible to receive Medicaid from Massachusetts. The local office servicing the community of residence and the Boston Administrative Service Office will receive notice of a child's eligibility from Central Office. If a child's parent(s) requests Medicaid from a local office as a result of a notice from another state, a copy of the notice should be forwarded to the office of the Associate Commissioner for Medical Payments.

When a child has been approved for Medicaid the child's parent(s) and local office will receive notification from Central Office. Although these cases will be carried and maintained on the recipient master file by Central Office, the local office is responsible for case maintenance activities such as issuing temporary MA-ID cards and authorizing transportation requests as with other DSS cases.

The cases will be identified on the RMF by a Budget Group Code of 4E (subsidized adoption) or 4F (foster care).

Children assisted under Title IV-E through DSS will continue to receive MA automatically.



4123: Only Child in Home Age 16 or Older, Not in School

An assistance unit that would be eligible for AFDC except that the only child in the home is over the age of 16 and has left school but has refused to register for ET is eligible for MA/AFDC. In order to be eligible for AFDC, a child 16 or over must be in school or registered for ET. MA has no school requirement, and ET is available only to recipients of cash assistance. Therefore, a single parent (or both parents when there is a deprivation factor) may be eligible for MA/AFDC along with their child between the ages of 16 and 21, whether or not he is in school.

4124: Only Child in Home Receives SSI

A single parent (or both parents when there is a deprivation factor) whose only child is a recipient of SSI is categorically eligible for MA/AFDC.

The SSI child's income and assets are not counted, and he is not included in the assistance unit. He receives his own medical I.D. card on SSI-D (Category 03).

EXAMPLE:

Eleanor Jenkins is divorced and has a 14 year old child who is receiving SSI. She works full-time.

The MA/AFDC filing/assistance unit consists of one. Eleanor is categorically eligible; the child could not manage without a caretaker relative.

Coding on T.D.

In order to enter an MA/AFDC case on the Turnaround Document, there must be a dependent in Section V. Therefore when the filing/assistance unit consists of only one person (pregnant woman or parent with only child on SSI), the worker enters the recipient's name in block 54 as well as in block 9. The dependent number for a pregnant woman is 91 and for a parent, 99.

The grantee is coded ineligible in block 20, and the number of eligible dependents (block 21) is "1".

4125: Eligible For AFDC Except For Excess Assets or Income

Assistance units that meet one of the deprivation factors and would be eligible for AFDC except that their assets or income or both exceed AFDC limitations may be eligible for MA/AFDC.



EXAMPLE 1: (Death)

Michael James is raising his three children as a single parent; he has a full-time job with earnings in excess of an AFDC budget for four. Mrs. James is deceased. The filing unit and the assistance units include Mr. James as well as the three children.

EXAMPLE 2: (Absence)

Nancy Farnsworth is divorced. She and her two daughters live with her parents. She works evenings as a waitress. As part of the divorce settlement, she received \$3,000. Nancy's present earnings are within AFDC limits but her assets make her ineligible. She and her daughters are categorically eligible for MA/AFDC.

EXAMPLE 3: Incapacity)

Joseph O'Neil and Cathy Brown's child is nine months old when Joseph is injured at work. He is expected to be out of work three months. His accident insurance exceeds the AFDC budget for three.

Joseph and Cathy still are not married, but if he has signed a legally binding agreement acknowledging paternity and his obligation to support the child, the filing unit and the assistance unit will now include all three. If the family has a spenddown, automatic eligibility for the child terminates with Cathy's eligibility and the child is not eligible again until the spenddown is met (See 4123).

EXAMPLE 4:

Joan and Paul Peters are expecting their first child. Paul has been laid off from his job. He collects \$100 per week in Unemployment Compensation.

The MA/AFDC filing unit consists of two and the assistance unit consists of one. The unborn child is deprived of parental support. When the child is born, the filing and assistance units consist of three. When Paul returns to work, MA/AFDC eligibility is terminated, and an application may be filed for MA/21 for the child (4136B).

4126: Grantee Relative Other Than ParentA. Single Grantee

A single grantee relative, other than the natural or adoptive parent of the child, may choose to be included in the assistance unit;



4126 (cont.)

If he wishes assistance for himself, his income and assets are counted in determining the financial eligibility of the entire assistance unit.

EXAMPLE:

The mother of the Davis twins is deceased. The father has remarried but the twins and their stepmother do not get along. They have gone to live with their Aunt Margaret. Mr. Davis pays her \$350 a month for their support. Her only other income is the rent paid for three apartments in the four-family house that she owns. She has no health insurance coverage and wishes to apply for MA.

Aunt Margaret's net rental income (see 5225) is added to the child support, and her assets are counted. Since the twins have nothing, if her assets do not exceed the limit for three people (5110), she may be eligible for MA/AFDC.

B. Married Grantee

If the grantee relative other than a parent is married, he and his spouse have the option of being included in the assistance unit only if there is a deprivation factor. If they choose to be included, their income and assets are also counted.

EXAMPLE:

Mr. and Mrs. Dawson have custody of their 17 year old granddaughter. Mrs. Dawson works full time, but Mr. Dawson has just suffered a heart attack and expects to be out of work several months. He is not sure whether his health insurance will cover all his bills and wishes to be included in the granddaughter's MA application.

Mr. and Mrs. Dawson have the option of having their income and assets counted and being included in the assistance unit because he is incapacitated. The filing unit consists of three and the assistance unit consists of three.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

## 4127: One Parent Receives SSI

In a two-parent family, if one parent is a recipient of SSI, the other parent and the child(ren) may be eligible for MA/AFDC.

### EXAMPLE:

Elizabeth Connelly receives SSI-Disability. She and her husband, Tom, have one daughter.

The MA/AFDC filing and assistance units consist of Tom and the child. Elizabeth's income is not counted, and she is not considered in determining family size.

If Elizabeth is awarded Social Security Disability benefits and the SSI-Disability is therefore terminated, she may apply for MA/DA or she may apply for MA/AFDC with her husband and daughter. Her income is no longer exempt from consideration in determining the eligibility of Tom and her daughter. (See 4141).

4130: AFDC-Related: MA Under 21

MA Under 21 does not involve a deprivation factor. Parents are responsible for their unemancipated children living with them until the age of 18. For unemancipated children not living with their parents and for all individuals ages 18-21 only the amount of income actually contributed by the parents is countable. The following individuals may be eligible for MA Under 21.

4131: Unemancipated Individual Under the Age of 18

If a filing unit includes a child(ren) under age two who meets the basic requirements of MA, and the filing unit's income is equal to or below the Federal Poverty Level income standard appropriate for its size, then the child(ren) under age two is eligible for MA without applying the asset standard. If other members of the filing unit are applying for MA, their eligibility is determined by using the MA income and asset standards.

In both situations, the income of all members of the filing unit (unless it is not advantageous to include siblings) is counted in determining financial eligibility.

A. Residing With Parents

When an unemancipated individual under the age of 18 resides with his parents, the parents' income is counted when determining the individual's financial eligibility.

EXAMPLE 1: No child(ren) under age two

Mr. and Mrs. Steinberg have four children ages six-15.  
Neither parent can establish a deprivation factor.

The filing unit includes all six, but the assistance unit includes the four children only.

EXAMPLE 2: Child(ren) under age two

Mr. and Mrs. J. have an 18-month-old baby, a six-month-old baby, and a seven-year-old child. Neither parent can establish a deprivation factor, and both are over 21.

The filing unit includes Mr. and Mrs. J. and their three children. The 18-month-old and six-month-old are one assistance unit. The filing unit's income is compared to the Federal Poverty Level income standard (Section 506.430). If the filing unit's income is below or equal to this amount, the babies are put on MA, and the seven-year-old's eligibility is determined by applying the asset standard and comparing the filing unit's income to the MA income standard (Section 506.410). Since the children have no income, the filing unit in both cases consists of five people.

If the filing unit's income is above the Federal Poverty Level income standard, then all three children are included in the same assistance unit, and the filing unit's income is compared to the MA income and asset standards.

B. Not Residing With Parents

If an unemancipated individual under the age of 18 is not residing with his parents, the income and assets of the parents are considered and counted in determining eligibility only when actually contributed. This individual shall not be denied assistance due to lack of parental support. If there is reasonable cause to believe that the individual is suffering from abuse and/or neglect, a referral should be made to the Department of Social Services.

If the child receives free room and/or board, or his parents or any other source pay his rent or room and/or board directly to the provider, this is considered income-in-kind. The amount(s) counted as income is the value from the income-in-kind table in Section 6070.

In cases of direct payment to the applicant or recipient, the amount of the payment is considered income in determining eligibility.

A form, the Affidavit of Parents' Contribution to Support (F4131B) has been developed to obtain the verification of parents' contribution(s). Before sending this form, the applicant or recipient must sign a Release of Information Form (F4131A). The affidavit form must be used to verify declared contributions. It should be used when declared income does not meet declared needs and the individual claims that the parents are not contributing. It must not be sent if no contribution is declared and declared income meets expenses.

Since many applicants or recipients in this group are students, the worker must note Noncountable Income that pertains to students (Section 505.230). Tuition payments are never considered as income to the student. During the summer and semester breaks, the individual is considered a student if he intends to register for the next term and has successfully completed the last term.

Also note that noncountable income must be verified by a statement from the appropriate agency(ies) indicating amount(s), frequency of payment(s), starting date, and other information appropriate to the specific grant, scholarship or work-study plan.

If an individual is covered under his parents' health insurance plan, then he should obtain the necessary information for the worker to correctly code the TD. He cannot be denied assistance if his parents will not cooperate.



Most college students are required to carry health insurance through the college unless they have coverage through their parents' plan. If a student claims no coverage, the worker must contact the college to inquire if health insurance is mandatory for their students. The worker must not use the student's name in making the inquiry. If the college official states that health insurance is mandatory for all students, the applicant or recipient must provide the information necessary for the worker to accurately code the TD.

EXAMPLE 1: With Grantee-Relative Other Than Parents

Mr. and Mrs. Dawson have custody of their granddaughter who is 17. They request medical assistance for the granddaughter but do not want coverage themselves.

The filing unit and the assistance unit both consist of the granddaughter alone. The grantee, who may be either of the grandparents, is not responsible for her.

If Mr. and Mrs. Dawson had adopted their granddaughter, or if they wanted coverage for themselves, the filing unit would consist of three. Their income and assets would be counted (see 4126B).

EXAMPLE 2: No Grantee-Relative

Jill Kirby is 16 years old. She lives with a school friend's family. Jill is a junior at the local high school. Her parents live in the same town and give her no money for support. Jill works 15 hours per week in a local bakery to pay for her clothes and social functions. Her friend's parents do not charge her for room and board. This family and Jill are satisfied with this arrangement, and Jill's parents do not want her home.

Jill is a filing unit of one, and her income consists of the income-in-kind values of heated shelter, utilities, and food for an individual.

After Jill has been receiving MA for four months, she calls the local office. She needs dental work but the dentist will not administer drugs without her parents' permission, and they will not discuss the matter with Jill.

The worker refers this case to the Department of Social Services.





# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

F4131A: Release of Information Form



*The Commonwealth of Massachusetts*  
*Executive Office of Human Services*  
*Department of Public Welfare*

RELEASE OF INFORMATION

I give permission to the Department of Public Welfare to contact my parents regarding their contribution(s) to my support.

Father's Name \_\_\_\_\_

Father's Address \_\_\_\_\_

Father's Phone No. \_\_\_\_\_

Mother's Name \_\_\_\_\_

Mother's Address \_\_\_\_\_

Mother's Phone No. \_\_\_\_\_

\_\_\_\_\_  
APPLICANT/RECIPIENT

\_\_\_\_\_  
DATE

WITNESSED BY:

\_\_\_\_\_  
FINANCIAL ASSISTANCE WORKER

MA-RI-1

F4131B: Affidavit of Parents Contribution to Support

*The Commonwealth of Massachusetts*  
*Executive Office of Human Services*  
*Department of Public Welfare*

Date: \_\_\_\_\_

Dear

Your son/daughter, \_\_\_\_\_  
 \_\_\_\_\_ Name  
 has applied/is being redetermined for Medical Assistance.

For us to determine his/her eligibility, it is necessary to know how much you contribute toward his/her support.

Do you provide a room rent-free? If No, how much do you charge?

☐ Yes ☐ No \$ \_\_\_\_\_  
 Amount Frequency

Do you provide his/her food at no cost? If No, how much do you charge?

☐ Yes ☐ No \$ \_\_\_\_\_  
 Amount Frequency

Do you contribute to his/her rent or other living expenses outside of your home?

☐ Yes ☐ No \$ \_\_\_\_\_  
 Amount Frequency

Do you pay tuition?

☐ Yes ☐ No \$ \_\_\_\_\_  
 Amount Frequency

Do you declare him/her as a dependent on your income tax return?

☐ Yes ☐ No

Are there any other contributions you make toward the support of your child?

☐ Yes ☐ No

If Yes, specify the type, amount and frequency of the contributions.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature (Father) \_\_\_\_\_

Signature (Mother) \_\_\_\_\_

Be sure to sign this form. Please note that Section 1909 Title XIX of the Social Security Act provides that fraudulent acts of false reporting in connection with the administration of the Medicaid Program are punishable by a fine of up to \$25,000, up to five years imprisonment, or both.

Financial Assistance Worker \_\_\_\_\_

Telephone \_\_\_\_\_

MA-PC

4132: Individual Eighteen (18) or Older

When an individual is 18 years old or older, his parents are not financially responsible for him. Their income and assets are considered and counted in determining his eligibility for MA/21 only when actually contributed. When declared, these contributions must be verified as with all other regular contributions. See Also Section 4131B.

When the parents' contribution consists of free room and/or board in their own home, the income-in-kind table in section 6070 is used. See Section 4131B

A. Individual 18 Years of Age or Older Residing with ParentsEXAMPLE 1: Non-Student

John, age 19, dropped out of school at 16, and has a spotty work history. He works 15 hours per week at minimum wage. He lives at home with his parents and four siblings and does not pay room and board.

John must verify his wages.

John is a filing unit of one. His countable income includes his wages, the income-in-kind values for heated shelter and utilities and the value of food for an individual. (See 6070.)

EXAMPLE 2: Full-time Student

Byron, age 19, is living at home with his parents and two siblings while attending the local college. He receives a partial tuition scholarship and has a loan made under a program administered by the U.S. Commissioner of Education. He works 15 hours per week at the minimum wage and receives \$75 per month from a trust set up by his grandparents. He pays \$15 per week for room and board. His parents do not give him any money, but he is included in their Blue Cross-Blue Shield plan.

Byron is a filing unit of one. After verification of his loan, scholarship, trust income, and wages (to ensure he is not employed full time), his countable income consists of the \$75 per month income from the trust.

B. Individual 18 Years of Age and Older Residing Apart from ParentsEXAMPLE 1: Full-time Student with Financial Contribution from Parents

Natalie, age 20, is sharing an apartment with three roommates while attending college full-time. Her share of the rent and utilities is \$195 per month which her parents pay directly to her landlord. She works as a model from five to twenty hours per week, and earns between \$25-75 per hour, depending on the assignment, which she receives from an agency. Her parents pay her tuition of \$3,375 per semester directly to the college.

Natalie is a filing unit of one. Worker receives the Affidavit of Parents' Contribution of Support, and verification of wages from the modeling agency. Natalie's countable income is the amount of the value of heated shelter and utilities from the income-in-kind table.

EXAMPLE 2: Full-time Student with no Contribution from Parents

Rhoda, age 18, attends college 200 miles from home. She shares a house with three other students. Rent, heat, and utilities are \$850 per month shared equally.

Rhoda's scholarships, loans, and grants are used toward her tuition, but she pays an additional \$1,400 per year. She works 15 hours each week-end at minimum wage. She claims she receives no contributions from her parents, and has no other income.

Since Rhoda's declared income does not meet her needs, she must have her parents sign the parents Affidavit form. She must bring in her most recent IRS 1040 or 1040A. (If she has filed Form 1040, the fact that she is claimed as a dependent by her parent(s) may be indicated in block 34a under "Computation").

If she refuses to furnish this or her parents refuse to sign the form, then the worker must make a referral to the Bureau of Special Investigations (BSI).

4133: Emancipated Minors (See 1500R)

Emancipated minors are categorically eligible for MA/21. Their parents have no responsibility for them.

EXAMPLE:

Earl Lawrence, age 17, has separated from his wife and is now living with his parents.

The filing unit consists of one, and the assistance unit consists of one because Earl is emancipated. Earl's parents' income and categorical eligibility are irrelevant. If he receives any contribution(s) from them, however, they are counted.

4134: Child in Custody of the Department of Social Services

A child in the care and custody of the Department of Social Services may be eligible for MA/21. The child is put on the Recipient Master File at Central Office.

4135: Child in Custody of a Private Social Service Agency

If a child is in the care and custody of a private social service agency, the agency makes application for him at the CSAO/WSO serving the community in which the agency is located. The living arrangement must be verified because if the child is in his parent's home, they are financially responsible, and must file the MA application.

Worker must see the custody papers because if the private agency is acting under a contract with DSS, eligibility is determined as in 4134.

If he is in the care of the private agency, the child is not emancipated, but is a filing unit of one, and only his income and assets are countable. The parents are not directly financially responsible for him, although they might be making contributions to his support to the agency. The agency should provide information regarding any health insurance coverage that the child might have.

4136: Child Not Eligible for Cash Assistance in AFDC or RRP Household

In families receiving AFDC there are often children who for various reasons are not eligible for AFDC. The child may be over the age of 16 and not in school or registered for WTP. If this is the only child the AFDC case is closed and assuming the deprivation factor continues, the parent(s) and child are eligible for MA/AFDC (4123). When there are other children who continue to receive AFDC, the one not eligible for AFDC may be covered on MA/21.



Children who are "self-sufficient" for AFDC purposes due to support or Social Security from an absent, deceased or incapacitated parent are categorically eligible for MA/21.

Although the parent is a grantee relative in two categories of assistance, he is eligible only in the AFDC assistance unit.

4137: Parents Under the Age of 21

If a parent(s) himself is under 21 years of age, he may receive MA along with his child(ren) even in an intact family.

EXAMPLE:

Frank and Julia Dempsey have one child. Frank is 20 years old and works full time. Julia is 21 and does not work.

The filing unit consists of three and the assistance unit consists of two, Frank and the child. A tickler file card should show when Frank will turn 21 so that he may be removed from the assistance unit.

4138: Persons Under 21 Receiving General Relief

In a GR family case, a separate Medical Assistance application should be filed for all family members under 21. Young adults under 21 who receive General Relief should also make application for MA/21.

4139: When There is a Stepparent

A child is considered deprived of parental support due to death or continued absence of the natural or adoptive parent even though the other parent has remarried.

A divorced or widowed parent who has remarried may apply for MA/21 for the children of the previous marriage. The assets and income of the children and the natural parent are considered, but the assets and income of the stepparent are not considered unless he/she wishes to be included in the assistance unit or the stepparent makes an actual contribution to a member of the assistance unit. For example see 4141. Inquiry should always be made concerning the stepparents' health insurance since a family policy usually covers stepchildren without additional charge.

If the stepparent adopts the children, he and his income are treated in the same manner as for a natural parent.



4200: AGE

The age of all individuals for whom assistance is requested under MA/21 as well as the age of all dependent children for whom assistance is requested on MA/AFDC must be verified.

4210: Verification of Age

If possible the applicant should provide the "long form" of the birth certification since this also established citizenship (3200) and is one link in establishing relationship (4300).

Obtaining a birth certificate does not usually present a problem for the applicant/recipient. The city or town hall will usually issue a birth certificate without charge for welfare purposes. Any person born in the United States after 1915 should be able to get a birth certificate. If town or city hall records have been destroyed by fire, flood, etc, a copy may be obtained from the state capitol. (See Appendix #3)

4220: Alternative Verification

In the rare situation when it is impossible to produce a birth certificate within the time limit for establishing eligibility, age may be verified by:

baptismal certificate;

family Bible or genealogical records;

passport;

hospital birth records;

U.S. census records;

Social Security benefit records;

immigration and naturalization records;

court records of adoption, adjudication of support, adjudication of paternity;

school records;

insurance policies;

newspaper records and local histories;

Indian agency records;

child welfare social service records;

voluntary social service records;

Head Start Program records;

day care center records;

other governmental records; or

an affidavit of a third person who has first hand knowlege of the circumstances. An affidavit may only be accepted as proof of age if the applicant or recipient demonstrates that he has tried to obtain an appropriate document.

4230: Assistance by Eligibility Worker

If the applicant is illiterate or does not speak and write English and has no one to write for him, it is the worker's responsibility to assist him in obtaining verification of age. The applicant is responsible for bringing his own interpreter to the office.

4300 - RELATIONSHIP AND LIVING ARRANGEMENTS4310: MA/21

Relationship is not a categorical issue under MA/21. A child under the age of 18 who has not been emancipated is the responsibility of his parents even though he may be living apart from them, and the parents must be contacted to determine the available resources. If the worker has reason to believe that a child under the age of 18 is living in a dangerous or unhealthy environment, a referral to the Department of Social Services should be made in accordance with a 1976 decision in the case of Critelli v. Sharp.

4320: MA/AFDC

In order to be eligible for AFDC the dependent child must be living with at least one adult to whom he is related in one of the following ways:

- A. a blood relative, including a mother, father, sister, brother, niece, nephew, aunt, uncle or first cousin, or any of these relatives of the preceding generation as denoted by prefixes of grand, great, or great-great. (Second and third cousins are not included under this definition. Blood relatives include those of half blood.);
- B. stepfather, stepmother, stepbrother or stepsister;
- C. a parent by legal adoption or any of the adopting parent's blood relatives as defined above, natural children, or adopted children; or
- D. a spouse of any person named above even if the marriage has been terminated by death or divorce.

4321: Verification of Relationship

Relationship between the dependent child and the grantee relative should be verified by "long form" birth certificates and/or marriage certificates.

In the rare situations where these records cannot be obtained (such as when birth or marriage took place in a foreign country that does not keep records or that will not cooperate in producing such records), school records showing the name and address of the child and the name and relationship of the relative responsible for the child may be substituted. For a preschool child in such a situation, relationship may be verified in the same manner as age (4220).

Relationship of a spouse and/or in-laws is verified by a marriage certificate or license. In a relationship more distant than parent/child each relationship must be verified.

4322: Extended Relationship

Ann Brown's parents are deceased. She lives with her mother's sister, Florence Durkin.

The following verifications prove the relationship:

- A. Ann's birth certificate showing her mother's maiden name;



4322 (con't)

- B. Ann's mother's birth certificate showing the names of her parents;
- C. Florence's birth certificate showing the names of her parents (at least one the same as Ann's); and
- D. Florence's marriage certificate showing her present name as Durkin.

EXAMPLE:

Carol is living with a family friend she has always called "Aunt Jean". Jean is actually Carol's stepfather's first wife.

The following verifications prove the relationship:

- A. Birth certificate showing Carol's and her mother's names;
- B. Marriage certificate showing names of Carol's mother and stepfather; and
- C. Divorce decree showing names of Carol's stepfather and his first wife, Jean.

NOTE: If the applicant cannot furnish proof of relationship, the application should not necessarily be denied. The child may be categorically eligible for MA/21 (4130).

4323: Establishment of Paternity

Paternity is established for purposes of MA/AFDC eligibility when the alleged father of a child:

- A. is legally married to the mother (or was legally married to her at the time of the conception or birth of the child);
- B. has entered into a common-law marriage with the mother in a state in which the common-law marriage is valid. Common-law marriage cannot be legally entered into in Massachusetts;
- C. has been found to be the father in adjudication by a court;
- D. has completed a legally binding agreement acknowledging paternity and his obligation to support the child and the agreement has been signed by both the father and the mother; or

4323 (con't)

- E. has completed a voluntary acknowledgment of paternity (Form A-35). Verification.

Verification

If verification is necessary, the establishment of paternity is verified by marriage or court records or a voluntary acknowledgment of paternity, as evidenced by the applicant/recipient's signature or a Form A-35.

4330: Living Arrangements

In order to be eligible for MA/AFDC, a child must be living with a grantee relative as defined in 4315.

4331: Temporary Absence

Although the dependent child must make his home with the grantee relative in order to be eligible for MA/AFDC, he need not always be staying in the home. A child may attend school away from home or leave the home on visits or for a summer job. If the grantee relative or child is in an acute hospital, they are still considered to be living together. Such absence should be recorded on the application/ redetermination form and verified if it lasts or is expected to last more than 30 days.

4332: Dual Custody

If a child lives part time with his mother and part time with his father as the result of a shared custody agreement, only one may file an application. If the child is of school age, he is considered to be residing in the home listed on the school records. The issue of support and health insurance coverage by both parents must be explored (3310).

4333: Child on Probation or in Custody of Court

A child on probation or in protective custody of the court who continues to live with his parent(s) is still considered to be living in the home. If he is in physical custody of a public or licensed private agency, however, he is not considered to be living in the home. If he lives with another grantee relative listed in 4315, that relative may file an application in his behalf. Availability of support from the parent must be explored.

4334: Verification of Living Arrangement

If there is any doubt concerning a child's living arrangement, with written permission the worker contacts the school and requests school records that show the the address of the child and the name of the person responsible for him. For a preschool child, the living arrangement may be verified by one or more of the following:

- A. worker observation during a home visit;
- B. hospital or clinical records;

4334 (con't)

- C. public housing authority records;
- D. court support orders;
- E. signed physician's statement;
- F. juvenile court records.

4335: Change in Living Arrangements

Any change in living arrangements must be reported to the local office within ten days. If such a change is not reported and would have resulted in ineligibility or in a larger spend-down liability (6500), when the fact does become known the case is referred for fraud (2800).

In an MA/AFDC case, if the child who turns 21 or leaves the home is the only eligible child, the categorical eligibility, of the parent(s) is terminated unless there is another child in the home receiving SSI.

4400 - DEPRIVATION

Whether a family unit may be considered for MA/AFDC or MA/21 depends on whether or not there is a child who is deprived of the care and support of either natural or adoptive parent.

There are four deprivation factors that render a family or individual categorically eligible for MA/AFDC:

- A. Death;
- B. Continued absence;
- C. Incapacity;
- D. Unemployment or underemployment of the parent who is the principal earner;

In AFDC terminology "dependent" does not have the same meaning that it has when one is filing his income tax return. A "dependent" child is one who is deprived of the care or support of at least one natural or adoptive parent (whether or not the parents were ever married to each other) due to death, continued absence, physical or mental incapacity, or the unemployment or underemployment (that is, less than one hundred hours per month) of the parent who is the principal earner.

4410: Death

A child is considered deprived of care and support due to the death of the natural or adoptive parent whether or not the other parent remarries.

4411: Verification of Death

Death must be verified, preferably by a copy of the death certificate. In the unusual situation where a death certificate cannot be obtained, death is verified by one of the documents listed in 106 CMR 504.410.

If the applicant/recipient believes the parent of his child to be deceased but cannot furnish proof by any of the above means, deprivation may be established by reason of continued absence.

4412: Potential Resources

When the natural or adoptive parent is deceased, the grantee relative must apply for Social Security Survivors Benefits, Veterans' Benefits and/or any other applicable benefits for which he may possibly be eligible. See Section 3300. Receipt of such benefits must be reported within ten days, and eligibility must be redetermined. If benefits are denied, a copy of the denial letter must be filed in the case record.



4420: Continued Absence

A child is considered deprived of the care or support of a parent when the parent is expected to be absent from the home for a period of at least 20 days. This deprivation factor prevails even if the absent parent has never lived with the child.

A child is also considered deprived of the care and support of a parent by reason of continued absence when the parent has been convicted of an offense and is under sentence of the court even though he may be permitted by the court to live at home and do unpaid public work or unpaid community service in order to comply with his sentence.

The applicant must complete an (A-30) form giving information about the absent parent. The continued absence of a parent must be verified in accordance with 504.420(B)(2). The appropriate source of verification depends on the reason and continuing nature of the absence.

4421: Verification of Continued Nature of the Absence

The Affidavit of Parental Absence (CA-1) is used to verify the continued nature of the absence of the parent and must be signed and dated at application, at redetermination and at the time of any appropriate case maintenance activity. A separate CA-1 must be completed for each absent parent.

In using the CA-1 as verification, the worker should explain to the applicant that he is signing the affidavit under penalty of perjury, and that making false statements to obtain MA constitutes fraud, and may result in the applicant's prosecution.

4422: Verification of the Reason for the Continued Absence

In some situations, the continued nature of an absence cannot be verified by official documents. (See 106 CMR 504.420 (B)(2) for a description of acceptable official documents). Such situations include instances of separation without a court decree, desertion and abandonment. In such situations there are two ways of verifying the continued nature of the absence.

- A. Evidence of the absent parent's residence outside the home; or
- B. Written statement by persons who have a professional relationship with the applicant or recipient that support his statement about the continued nature of the absence.

It is the applicant's responsibility to provide such evidence. If the applicant can document reason to fear the absent parent, it is the worker's responsibility to contact the absent parent and request verification.

- A. Evidence of the absent parent's residence outside the home includes:

- 1. a lease or rent receipt;
- 2. maintenance of a telephone at another address;
- 3. a notice of a change of address to the employer of the absent parent;
- 4. a notice of a change of address to the Postal Service;
- 5. case records of the Child Support Enforcement Unit;
- 6. union records;
- 7. probation office records;
- 8. DES records;
- 9. Unemployment Compensation records;
- 10. evidence of receipt of pension, Social Security, SSI, Veteran's or unemployment checks at another address;
- 11. driver's license, motor vehicle registration, and voter registration records or other documents showing another address;
- 12. police records;
- 13. Internal Revenue Service records.

- B. Persons with a professional relationship to the applicant/recipient include

- 1. doctors;
- 2. attorneys;
- 3. social workers;
- 4. employers;
- 5. law enforcement officers;
- 6. probation officers;
- 7. counselors; and
- 8. clergy.

Permission must be given for all collateral contacts.

If none of the verifications listed above is available, or the verification that is available does not clearly indicate that the absence is continued, the continued nature of absence must be verified by:

- . a signed and witnessed Affidavit of Parental Absence, Form CA-1. In using a CA-1 as verification, the applicant or recipient must be informed that he is making the affidavit under penalty of perjury, and that making false statements to obtain benefits constitutes fraud, which may be prosecuted.

4423: Absent Parent's Return

The recipient must be informed that if the absent parent returns to the home, this fact must be reported to the local office within ten days. Failure to do so requires a fraud referral.

If another deprivation factor exists (unemployment or incapacity) determine whether the case remains eligible for MA/AFDC when the second parent is added to the filing unit. If no deprivation factor exists, terminate the MA/AFDC case. An application for MA/21 may be filed.

4430: Incapacity

A child is considered deprived of care or support even though both parents are living in the home if either one of them has a physical or mental impairment or illness that prevents or substantially reduces his capacity to support or care for the child. The condition must have lasted or be expected to last at least 30 days. See 106 CMR 504.430(B) for a list of the acceptable verifications for incapacity.

4432: Monitoring of Incapacity

The statement by the competent medical authority must give the expected duration of the disability or illness. It then becomes the responsibility of the worker to furnish information for a tickler file maintained by the local office or the individual unit in order that the case, or at least the deprivation factor, be reviewed at the time the illness or incapacity is expected to end. A new medical report must be requested at that time. If the parent is no longer incapacitated, other deprivation factors such as unemployment are considered. If the unit is no longer eligible for MA/AFDC because there is no deprivation factor, eligibility for the child(ren) under MA/21 is explored.

4433: Potential Resources

If the incapacity is the result of an accident (automobile accident, industrial accident, etc.) the incapacitated parent must pursue any benefits resulting from a third party liability. (3400)

If the illness or incapacity lasts, or is expected to last, for six months, the incapacitated parent must apply for Social Security Disability Benefits and must provide the worker with a copy of the SSA's decision. (3302)

The worker should also suggest that the incapacitated parent apply for SSI. Such application, however, cannot be required.

The worker must stress that receipt of any benefits is to be reported immediately. If the applicant is denied the potential benefit, a copy of the denial letter is placed in the case record.



4440: Unemployment or Underemployment of the Principal EarnerHow to establish unemployment of the principal earner as the deprivation factor.

## I. Determine which of the two parents is the principal earner.

- ° Compute the total earnings for the mother for the 24 calendar months preceding the date of application.
- ° Compute the total earnings for the father for the 24 calendar months preceding the date of application.
- ° The parent who earned the greater amount is the principal earner.

NOTE: If the parents earned exactly the same, the worker decides who will be the principal earner.

Example 1: Freda Farnsworth has been working full time as a cashier in the local supermarket for the past three years while her husband, Frank, has attended school during most of the time. Although her gross annual income has only been \$8,300, she has managed to support the family adequately. Freda continued to work after Frank received his engineering degree in June. He was hired by a local construction firm in July at an annual salary of \$30,000 but was laid off after only six months on the job. In January, Frank applies for Medical Assistance since Freda must take a leave of absence from her job.

Although Frank's earnings for the past six months are substantially higher than his wife's, Freda is still considered the principal earner. Her earnings of \$16,000 in the past twenty-four months are greater than Frank's earnings of \$15,000 during the same period of time.

## II. Once the principal earner has been determined, the worker must verify that the principal earner:

- ° is unemployed or underemployed; and

Example 2: Andrew Mills has been employed as a substitute teacher since losing his full time job last year. His wife, Eileen, has not worked for the last four years. Andrew has worked only 9 days a month for the last three months but was able to work three full weeks (120 hours) this month while substituting for a teacher who was hospitalized. Upon his colleague's return to work, he anticipates his work schedule to be the same as it has been in previous months.

Andrew is working more than 100 hours in the current month. However, since this reflects an unusual situation that he does not anticipate recurring in the following month, and since he has established he has worked only 72 hours per month in the previous two months, his current excess can be considered of a temporary nature. He continues to meet the definition of underemployment.

- has a work history (see Example 3); and
- has applied for Unemployment Compensation; and
- has not refused a bona fide offer of employment or training for employment within the 30 day period prior to the date of application unless there was good cause.

Eligibility Factor	When to Verify	How to Verify
Establishing which parent is the principal earner (504.440A)	<ul style="list-style-type: none"> <li>◦ application</li> <li>◦ when establishing deprivation factor</li> </ul>	<ul style="list-style-type: none"> <li>◦ wage stubs or</li> <li>◦ written statement from former employers or</li> <li>◦ copies of federal income tax returns (If either or both parents are unable to provide these verifications, the worker will decide who will be the principal earner based on available information.)</li> </ul>
Unemployment* (504.440B)	<ul style="list-style-type: none"> <li>◦ application</li> <li>◦ redetermination</li> <li>◦ when establishing deprivation factor</li> </ul>	<ul style="list-style-type: none"> <li>◦ applicant/recipient declaration</li> </ul>
Underemployment* (504.440B)	<ul style="list-style-type: none"> <li>◦ application</li> <li>◦ redetermination</li> <li>◦ when establishing deprivation factor</li> </ul>	<ul style="list-style-type: none"> <li>◦ wage stubs or</li> <li>◦ statement from employer or former employer</li> </ul>



Eligibility Factor	When to Verify	How to Verify
Work History* (504.440C)	<ul style="list-style-type: none"> <li>◦ application</li> <li>◦ when establishing deprivation factor</li> </ul>	<ul style="list-style-type: none"> <li>◦ wage stubs</li> <li>or</li> <li>◦ written statement from former employer(s)</li> <li>or</li> <li>◦ W-2 forms</li> <li>or</li> <li>◦ documents from an employment agency</li> <li>or</li> <li>◦ business records from self-employment</li> <li>or</li> <li>◦ statement from Community Work Experience Program or ET</li> </ul>
Unemployment Compensation* (504.440D)	<ul style="list-style-type: none"> <li>◦ application</li> <li>◦ when establishing deprivation factor</li> </ul>	<ul style="list-style-type: none"> <li>◦ documents from DES</li> </ul>
Good cause for refusal of a bona fide offer(s) of employment or training (within 30 days prior to date of MA eligibility) (504.440E)	<ul style="list-style-type: none"> <li>◦ application</li> <li>◦ when establishing deprivation factor</li> </ul>	See 106 CMR 307.180(B)

\* Verification required for principal earner only.

Example 3: John Doe, his wife and child applied for MA-AFDC on 7-15-83. John has never worked, but his wife has. To determine whether she meets the work history requirement, the worker constructs the chart as shown on the following page.

- . In column I, list the 17 quarters preceding the MA application.
- . In column II, place an "X" opposite each quarter in which Mrs. Doe earned \$50 or more.
- . In column III, draw brackets to distinguish the five sets of 13 consecutive calendar quarters ending within one (1) year of the MA application.

If any one or more of the brackets in column III encompasses six or more of the "X"'s in column II, the principal earner meets the work history requirement.

WORK HISTORY REQUIREMENT

I	II	III
Quarters preceding MA-AFDC application	Quarters in which Principal Earner was employed, in ET or its predecessors, or a Community Work Experience Program	13 Consecutive Calendar Quarters
April-June 1983 January-March	X	
October-December	X	
July-September 1982 April-June	X	
January-March	X	
October-December	X	
July-September 1981 April-June	X	
January-March	X	
October-December	X	
July-September 1980 April-June	X	
January-March	X	
October-December	X	
July-September 1979 April-June	X	

## 4500: SSI-RELATED PROGRAMS

SSI

Current recipients of Supplemental Security Income for the Aged (SSI-A) and Supplemental Security Income for the Disabled (SSI-D) are categorically needy recipients of Medical Assistance.

MA/OAA

Medicaid related to Old Age Assistance provides Medical Assistance to eligible persons aged 65 and over. An MA/OAA assistance unit consists of one person, but the filing unit may consist of two or more in cases where spouses are mutually responsible for each other or income is deemed to a minor child.

MA/DA

Medicaid related to Disability Assistance provides Medical Assistance to eligible persons under the age of 65 who are disabled according to the standards of the Social Security Administration. An MA/DA assistance unit consists of one person, but the filing unit may consist of two or more in cases where spouses are mutually responsible for each other or income is deemed to a minor child.

PICKLE CASES

The Pickle Amendment to the Social Security Act allows certain former SSI recipients who became ineligible for SSI cash assistance after April 1977 to retain (or regain) their eligibility for Medical Assistance if they now receive RSDI benefits and would be eligible for SSI if the amount of all Social Security cost-of-living increases received since the termination of SSI were deducted from present income.

MASS REHAB PERSONAL CARE ATTENDANT CASES

Individuals who receive at least 14 hours per week of Personal Care Attendant (PCA) services provided and paid for by the Massachusetts Rehabilitation Commission (MRC) are automatically eligible for Medical Assistance. They do not have to meet either the categorical or financial requirements of the MA Program and do not receive Federal Financial Participation (FFP.)



4510: SSI Recipients: Automatic Eligibility

4510

Current SSI recipients receive MA under SSI-A (category 1) and SSI-D (category 3). No separate MA application is required unless the recipient requests retroactive MA benefits.

SSI cases are entered on the Recipient Master File via the State Data Exchange System (SDX). If a recipient whose name does not appear on the File presents a copy of his or her award letter or current benefit check or a form from the Social Security Administration stating that his or her SSI application has been approved, the worker may enter the case by means of a TD so that medical bills will be paid. SSI blind recipients should be referred to MCB.

A person in the local office designated by the Director is responsible for authorizing payments for certain special benefits, such as disaster, moving, burial, etc. to SSI recipients in accordance with the requirements of 106 CMR 327.040.

If an SSI recipient is terminated from SSI, MA coverage may not be terminated without a separate determination of eligibility for MA. (See Sections 2222 and 4534.)

4511: SSI Applicants

SSI applicants are not required to file a separate application for MA unless they request retroactive MA benefits. If an SSI applicant wishes to apply for MA during the period when his SSI application is pending, the MA application must be taken and processed in a timely manner. (If the SSI applicant is applying for MA/DA, block 19 on the Disability Determination tracking form should be checked.)

4512: Spouse Essential to Care

Prior to the inception of the SSI program in January 1974, the Department administered the Old Age Assistance (OAA) and the Disability (DA) Programs. In some cases the Department determined a spouse to be essential to the care of the OAA or DA recipient and granted Medical Assistance to the spouse.

Although SSI does not have such a program, individuals who received MA as "spouses essential to care" were "grandfathered in," and a few remain on the rolls. To qualify under this provision, the spouse must still be living with the same elderly or disabled recipient as in December 1973 and must still be essential to his or her care, that is, without the spouse's care, the recipient would require institutionalization. The "spouse essential to care" is an individual who cannot establish eligibility for MA on his or her own. He or she is covered as a dependent.

A spouse essential to care who was not eligible for MA prior to 1/1/74 may apply for medical coverage under the General Relief Program.

The "essential to care" status must be verified by a letter or other written statement from a competent medical authority indicating that the recipient could not remain in the community without the spouse's care.



4520: Medicaid Related to Old Age Assistance (MA/OAA)

4520

The MA/OAA Program is intended primarily for persons 65 years of age or older who would be eligible for SSI-A except that their income and/or assets exceed SSI standards or who would be eligible for SSI-A but only wish to receive MA.

Workers should be familiar with the SSI eligibility standards so that they can refer individuals who appear to be eligible for the cash program to the nearest office of the Social Security Administration.

SSI community income standards, for married couples, are generally higher than MA standards. Also, because of the Pickle Amendment, a person who has once received SSI will be more likely to regain medical coverage in the future as Social Security cost-of-living increases accumulate. On the other hand, an individual who needs long-term care will almost certainly need to apply for MA since only a person with total monthly income of less than \$85.00 would be eligible for SSI in a long-term-care facility.

4530: Medicaid Related to Disability Assistance (MA/DA)

The MA/DA Program is intended primarily for disabled individuals who would be eligible for SSI-D except that their income and/or assets exceed SSI standards, or who would be eligible for SSI-D but only wish to receive MA. SSI and MA/DA do not set a minimum age for disability and it is often financially advantageous for a disabled child to be considered for MA/DA rather than MA/21.

4531: Determination of Disability

Disability is determined by the Disability Determination Unit (DDU) or by the receipt of Social Security Disability benefits (RSDI). (See 4710.) An eligibility worker may never make the decision on his or her own to deny or terminate assistance on the grounds that the individual is not disabled.

4532: MA Eligibility for GR Recipients

The General Relief Program does not provide the same range of medical benefits as the federally funded MA program. GR applicants or recipients may apply for and, if they meet the categorical and financial criteria, be found eligible for any MA category. An applicant or recipient of GR may be required to apply for SSI-D as a condition for receiving General Relief, but this is not a requirement for receiving MA. The application will be processed in the same manner and according to the same time standards as all other MA/DA applications.

The MA worker must notify the GR worker if the application of a GR applicant or recipient is approved. If the SSI-D application is later denied by SSI on the grounds that the individual is not disabled, the MA/DA case must be terminated immediately.



4533: MA Eligibility for GR Recipients Residing In Rest Homes

When an individual who requires rest home care has too much income to be eligible for SSI but does not have sufficient income to meet the cost of the rest home, he or she may receive General Relief (GR) in an amount that when added to his or her other income is sufficient to pay the rest home and allow for retention of a Personal Needs Allowance (PNA). The individual must meet all GR requirements.

A GR recipient's income is not countable for purposes of MA eligibility (Section 505.230). If the GR recipient meets the basic and categorical requirements of the MA Program (i.e. SSA or DDU Disability, is over 65, or is under 21), he or she is eligible for MA regardless of his or her other income.

Example: Mrs. Dody is disabled and lives in a rest home. She receives \$525.00 per month in RSDI Disability Benefits. This amount exceeds the SSI standard for a rest home resident, making her ineligible for SSI. Since she has never received SSI, she is not eligible for MA as a Pickle case.

Mrs. Dody receives a GR check to supplement her payment to the rest home and provide a Personal Needs Allowance (PNA). The amount of the check is determined as follows:

\$546.00	-	Monthly rest home bill (\$18.00/day x 7 x 4.3333)
+70.00	-	PNA
<u>\$616.00</u>		
<u>-525.00</u>	-	Mrs. Dody's RSDI income
\$ 91.00	-	Amount of General Relief (payable to Mrs. Dody who in turn pays the rest home)

Mrs. Dody meets all the basic MA eligibility requirements. She receives RSDI disability benefits and therefore meets the categorical requirements of MA/DA. Since she is a GR recipient none of her income is countable. She is eligible for MA/DA without a spenddown.

4534: SSI/D Denials and Terminations

An MA/DA applicant who is denied or terminated from SSI-D because of a decision that he or she is not disabled must have an independent disability decision made by DDU. This does not apply to those MA/DA recipients that were "grandfathered in" prior to 1/1/74.

A recipient who is terminated from SSI-D may still be eligible for MA/DA with or without a spenddown, but unless he or she is currently receiving Social Security Disability benefits, his or her disability must be approved by DDU. (See 4710)

An individual whose SSI cash assistance is denied or terminated because of his or her refusal to accept SSI's referral for treatment of alcohol or drug abuse may still be eligible to receive MA/DA.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

## 4535: Advising Individual Regarding Application for MA/DA or SSI-D

It is your obligation to advise applicants and potential applicants for MA/DA or SSI-D concerning the aspects of each program that will be most advantageous to them. Although SSI is usually more advantageous than MA, be sure to explain that

- 
- ° An individual who appears to be disabled must apply for SSI in order to be eligible for General Relief.
- 
- ° No one can be required to apply for SSI as a condition for receiving MA only.
- 
- ° Although MA-only recipients can have more countable assets than SSI recipients, SSI recipients can have considerably more monthly income.
- 
- ° An application for SSI-D is also an application for MA.
- 
- ° An individual who has already applied for SSI-D but whose eligibility has not been determined may apply for MA/DA also if he or she wishes.
- 
- ° An individual approved after 1/1/74 by the Disability Determination Unit (DDU) but later denied by SSA for SSI on the grounds that he or she does not meet the definition of "disabled" must have his or her disability determination made by DDU.
- 
- ° Because of the Pickle Amendment, an individual who has once received SSI is less likely to lose medical coverage in the future due to excess income than an individual who has never received SSI.
- 
- ° An MA/DA application by an individual who is in an acute hospital awaiting long-term-care placement will be handled as a priority by the Disability Determination Unit.
-

4540: Pickle Cases

The standards used to determine eligibility for Pickle cases are so completely different from any other cases with which the worker must be concerned that they are treated separately in Chapter 8.

4550: Mass. Rehab. Commission PCA Cases

The Massachusetts Rehabilitation Commission (MRC) provides Personal Care Attendant services to handicapped individuals who could engage in gainful employment if they had assistance with routine functions such as dressing, bathing and preparing food.

No eligibility determination is made by the Department for these cases, and no Federal Financial Participation is received.

Potential recipients for this program should be referred to the local office of the MRC. If PCA services are provided at least 14 hours per week, MRC will notify the Department, and MA eligibility is automatic, with the category depending on the individual's age.

Under 21	MA/21
Between 21 and 65	MA/DA
65 and over	MA/OAA

These cases are added to the Recipient Master File and maintained Centrally.

4600: AGE

Since the only categorical eligibility requirement for the MA/OAA program is the attainment of age 65, an applicant's age must be verified. Verification of age is not a mandatory requirement of MA/DA since a person under 21 would be categorically eligible for MA-21 and a person 65 or older would be categorically eligible for MA/OAA. However, the birth certificate will probably still be necessary in order to verify citizenship for MA/DA applicants.





# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

4610

## 4610: MA/OAA

Since the only categorical eligibility requirement for the MA/OAA program is the attainment of age 65, an applicant's age must be verified.

The age of an applicant/recipient shall be verified by one of the following:

- (1) Birth certificate
- (2) Hospital Birth record
- (3) Records verified by the Social Security Administration (SSA):  
A printed copy of the Bendex File Record (ADABAS screen "H") or SDX documentation (either the SDX/SSA 8036 or a printed copy of the "D" screen). If a WSO does not have a VDT or printing capacity on the VDT, the copy of screen "H" or "D" must be requested from the Data Entry Clerk at the CSAO.
- (4) Pending update of the Bendex File on ADABAS, age may be verified by a Social Security Benefit Record (green check) and a Medicare card. If age is verified in this manner, the worker must so note in the case record and obtain other proof of age no later than the next redetermination.

If none of the above documents is available, two (2) of the following may be accepted, provided at least one (1) contains the date of birth and the other is dated and contains the age:

- a. Family bible or genealogical records;
- b. Baptismal certificate;
- c. Insurance policies;
- d. United States census records;
- e. Immigration and Naturalization records;
- f. Employment records;
- g. Newspaper records and local histories;
- h. Indian agency records;
- i. Voluntary social service records;
- j. Church records;
- k. Passport records;
- l. other governmental records; or



- m. an affidavit of a third person, who has first-hand knowledge of the circumstances if the applicant has demonstrated that he has tried to obtain appropriate documents. The case record should show the reason by which the person making the affidavit would have had reason to know the facts.

There will be instances in which a person's name differs from that on the birth certificate. Should the worker have cause to suspect the applicant is misrepresenting himself or presenting a birth certificate that is not his own, he should request further verification to establish a linkage between the two names. Acceptable documentation would be marriage certificates or licenses, adoption papers, or other court documents or religious records establishing a change of name.

It may not always be possible to provide documented proof of a name change since an individual is free to assume any name he chooses without court approval, provided this is not done for purposes of misrepresentation. In such an instance, a requirement of official verification of some kind is unreasonable. However, the Department may question the applicant to determine when the name change was made. The individual may also be asked to provide proof that he has used the name since the time of the change. Reasonable "proof" would be utility bills, voter registration records, employment records, or other such documentation. The Department may, in addition, request an affidavit from the individual attesting to the use of the new name.



4700: Permanent and Total Disability

4700

Disability as defined in Title XVI of the Social Security Act (4530), is the only categorical requirement of MA/DA and as such must be verified.

4710: Verification of Disability

Permanent and total disability is verified in two ways.

A. Receipt of RSDI Disability Benefits

Current receipt of Social Security disability benefits automatically verifies eligibility. The fact that Social Security benefits are, in fact, based on the recipient's own disability rather than widow's benefits or early retirement may be verified by:

1. a document from the Social Security Administration certifying eligibility for Social Security Disability Benefits (RSDI); or
2. a copy of the recipient's Medicare card. (Persons receiving benefits based on widow's benefits or early retirement are not entitled to Medicare benefits.)

B. Decision of Disability Determination Unit (DDU)

Evaluation of permanent and total disability is made by a Disability Determination Unit designated by the Department. The Massachusetts Rehabilitation Commission's (MRC) Disability Determination Services (DDS) is the designated DDU. It is their responsibility to decide if an applicant or recipient meets, or continues to meet, the Title XVI definition of disability.

DDU may either "waive" an applicant, in which case medical records need not be submitted upon redetermination of financial eligibility, or it may approve eligibility for a specific period of time (one year, two years, etc.)

If the case is approved for a certain length of time only, the local office should notify the recipient at least a month before the end of the approval period of the need to reevaluate the disability determination.

4715: Termination of SSI for Financial Reasons

If a recipient of SSI-D is terminated because of excess assets and/or income, he or she may still be eligible for medical assistance under MA/DA. If he or she is not currently receiving Social Security Disability benefits (4710), only the tracking sheet of the MA/DA Application Supplement is to be completed and sent to DDU.



4720: Submitting the Case to DDU

4720

The MA/DA Application Supplement is a supplement to the MA Application (SS-37) and is considered part of the application unless an applicant or recipient is currently receiving Social Security Disability benefits. Applicants should be advised that an application for MA/DA is not complete unless the supplement is also completed. The application date is the date that both forms are completed.

The MA/DA Application Supplement form must be submitted to the:

Massachusetts Rehabilitation Commission  
Disability Determination Services  
110 Chauncy Street (Intake Unit)  
Boston, MA 02111

The information recorded on the form is very important. It can often make the difference between approval and disapproval and may reduce the time that it takes DDU to reach a disposition.

The first page of the form is completed by the worker. It captures identifying information about the applicant and the local office and will be used as a tracking form between the worker and DDU. Workers should make sure that information on this page is accurate and complete, as this page acts as a cover letter for DDU. The tracking sheet must be checked for "type of case" (e.g. initial, redetermination or SSI termination) as well as checked for priority decisions. DDU will prioritize the disability determinations accordingly and the decision will be sent to the worker on the second half of the tracking sheet, completed by DDU. In the case of an SSI termination, only the tracking sheet is completed. Priority applications should also be checked on the tracking sheet and any appropriate comments noted in the remarks section.

Parts I-VI of the form are completed by the applicant. Part I asks for basic information about the applicant's medical condition and how it has affected his or her ability to work. Part II of the form asks the applicant to list all physicians, hospitals, clinics, etc., that have treated him or her and to give signed permission for the Department to obtain medical records from these sources. Workers should make sure the applicant has signed a separate medical release for each provider listed and two blank releases. DDU will forward the medical releases with the original signatures to each provider.

Part III of the form describes the applicant's daily activities. This information can provide an important supplement to the physician's impressions of the applicant's "residual functional capacity," i.e., "what the applicant can do."



[illegible]

THE 2001-2002 DIRECTORIES FOR FRODOGARDEN

THE HEDLEY ASSISTANCE

EDGE REGION BOTH THE NEW AND OLD SECTIONS OF 4725 AND 4736. THE ROUTINE SECTION HAS MADE THE PARALLEL THIN. MEDICAL 600151Z JUL

ADDITIONAL FBI HQ FILE 156-2 CIVIL NO 12 SENT FOR AN APPLICATION WITH  
DEFS BACKLOG. IF AN APPLICATION SUBMITTED DURING FOR THE HQ FILE.

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SELECT FUNCTION, FILE, COPIES FROM
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QUEST. PLEASE CALL THE HOT LINE FOR THE TRACT HOME.

AND I AM NOT AN INDIVIDUAL. THIS IS MY NAME. I AM NOT



Parts IV and V ask for the applicant's work history and educational background. A DDU decision must take into consideration the applicant's age, educational level, vocational training and work history as well as factors such as illiteracy and language barriers. It is as important for DDU to have accurate information about these factors as it is to have an accurate medical diagnosis and prognosis.

DDU looks at an applicant's work history in light of jobs or training within the past 15 years. Job experience or job training that is more than 15 years old does not usually offer a reasonable alternative for the applicant who cannot perform his or her usual work. Be sure the applicant includes current employment, if any.

Part VII of the form asks for the interviewer's observations of the applicant. These observations are important to the disability determination and should be completed, if possible. Have the applicant come into the office as Part VII cannot be completed by the applicant. If this is not possible, ask the applicant to have a medical social worker (in a hospital, nursing home, institution, or community health agency where the applicant is a patient) complete Part VII.

4725: Responsibilities of Disability Determination Unit

Upon receipt of the completed form, DDU will send for medical records from all providers listed by the applicant. (Although workers are not responsible for obtaining medical evidence, they should submit any available records to DDU along with the MA/DA Application Supplement.) If, after receipt of the medical records, more information is required, DDU will arrange for a consultative assessment by a specialist located in the applicant's geographic area. Since DDU contracts with these specialists independently, neither the applicant nor MA will be billed for the examination.

DDU will render a disability decision based on the applicant's medical records and the information contained in the form. The written determination will be sent to the worker who will then notify the applicant of the decision.

Should the applicant appeal the decision, DDU will send a disability examiner and/or physician to the fair hearing. The worker remains responsible for representing the Department where the issue is basic or financial eligibility.

4730: Expiration of DDU Approval

If an MA/DA case is approved by DDU for a limited time, a new MA/DA Application Supplement must be submitted prior to the last day of the month in which the approval terminates. The MA/DA case must not be terminated for lack of categorical eligibility until a disability decision is rendered by DDU.



4725: SS-33 DISABILITY REPORT

Use the SS-33 (Rev. 9/86) to record the applicant's medical, social and work history and to send this information to the State Medical Review Team (SMRT). The information recorded on the SS-33 is very important. It can often make the difference between approval and disapproval and may reduce the time that it takes SMRT to reach a disposition.

Use the SS-33 to describe the applicant's daily activities. This information can provide an important supplement to the physician's impressions of the applicant's "residual functional capacity", i.e. "what the applicant can do".

Pages 10 and 11 ask for the interviewer's observations of the applicant. These observations are important to the disability determination and should be completed, if at all possible. Have the applicant come into the office as pages 10 and 11 cannot be completed by the applicant. If this is not possible, ask the applicant to have a medical social worker (in a hospital, nursing home, institution or community health agency where the applicant is a patient) to complete pages 10 and 11.

A SMRT decision must take into consideration the applicant's age, educational level, vocational training and work history as well as factors such as illiteracy and language barriers. It is as important for SMRT to have accurate information about these factors as it is to have an accurate medical diagnosis and prognosis.

SMRT looks at an applicant's work history in light of jobs or training within the past fifteen years. Job experience or job training that is more than fifteen years old does not usually offer a reasonable alternative for the applicant who cannot perform his/her usual work. Be sure to include current employment, if any.

4726: DEFERRALS AND TEMPORARY MEDICAL ASSISTANCE

Sometimes the State Medical Review Team (SMRT) confronts barriers to the eligibility determination process (e.g. physicians are sometimes slow in providing needed documentation of diagnosis and prognosis). In these situations, it is necessary for SMRT to "defer" the disposition on the case. This deferral provides SMRT the time which is required to develop an accurate determination of disability. To provide the applicant with access to medical services during this period, the Department provides TEMPORARY MEDICAL ASSISTANCE. If the applicant is already receiving MA on another category, he has access to medical services.

Two new forms have been developed to notify applicants of this benefit, the Approval for Temporary Medical Assistance, MA/NFL-TMA-1, and the explanation of the Temporary Medical Assistance "spenddown", MA/NFL-TMA-2.

When an application is deferred, you will receive a notification from SMRT which informs you that the applicant can get Temporary Medical Assistance. Temporary Medical Assistance begins on the date that notification from SMRT is received in the local office and extends until the last day of the third full calendar month after the notification.



For example: On March 3 you receive notification that Mr. Jones' application for MA/DA has been deferred. Mr. Jones is financially eligible. The period during which he receives Temporary Medical Assistance is March 3 through June 30. Send MA/NFL-TMA-1.

Spenddowns, if they apply, are prorated over the three month temporary medical assistance period. To meet his spenddown an applicant may use medical bills that were incurred on or after the date the SMRT notice was received in the local office.

Example using Mr. Jones from preceding paragraph:

\$750	- Mr. Jones' pension
- 20	- Unearned income deduction
<u>\$730</u>	- Countable monthly income
-451	- MA Standard for one
<u>\$279</u>	- Excess monthly income
x 3	-
<u>\$837</u>	- Temporary Medical Assistance Spenddown

Any medical bills incurred by Mr. Jones from March 3 - June 30, may be used toward meeting this spenddown.

Worker must send Mr. Jones an MA/NFL-TMA-2 to explain his spenddown. If he meets his spenddown before June 30, worker must send the MA/NFL-TMA-1.

When establishing a case on Temporary Medical Assistance, you must:

- \* Establish a tickler file to track the case; and
- \* Complete a TD using AR code 10 in Block 19 to denote Temporary Medical Assistance, and the initial date of Temporary Medical Assistance in block 17.

SMRT assumes the responsibility for collecting any additional data that is needed to make a determination of disability.

SMRT will notify you of an approval or denial by the expiration of the Temporary Medical Assistance Period. If the case is approved, you must:

- \* change the code in block 19 of the TD to code 02;
- \* change the medical start date in block 17 of the TD; and
- \* proceed as for any other approval.

If SMRT denies the case, close the Temporary Medical Assistance case as of the last day of the Temporary Medical Assistance Period, using closing code 36 in block 19. You must then deny the application and send the MA/NFL-5 using the appropriate manual citation.

NOTE: A monthly report will be issued entitled "Report of Temporary Medical Assistance Cases (SMRT Referrals)" that will include each case's last date of Temporary Medical Assistance.



4730: Timeliness Requirement

If a medical report is not received within fifteen days of the initial request, the worker must send a second request to the physicians and/or hospitals listed in Section 19 of the application. If the completed SS-32 is not received by the 30th day, the worker must submit all medical reports that he has received to SMRT with the SS-33. Additional medical records received after the original submission to SMRT may be forwarded with a cover memo. If the team has already reviewed the case, and it has been denied, an appeal should be filed and the new evidence submitted.

Copies of all medical reports should be made for the case record before the originals are sent to SMRT.



4800: Refugee Resettlement Program

The Refugee Resettlement Program was established by the Refugee Act of 1980. Under this act, federal funding is allocated to designated agencies to provide for the basic needs and resettlement services of individuals admitted to the United States as refugees.

The Executive Office of Human Services (EOHS) through its agent the Office for Refugees and Immigrants (ORI) is responsible for the coordination and delivery of certain services to refugees. EOHS, through an interagency agreement, has designated the Department of Public Welfare as the agency responsible for the delivery of cash and medical assistance to refugees.

All RRP cash and medical assistance cases are assigned to seven local welfare offices. The offices are Attleboro, Boston (Hamilton Place), Chelsea, Lowell, Lynn, Worcester, and Springfield. These offices have bilingual Refugee Case Managers and Supervisors who have only RRP cases and are responsible for both cash and medical assistance. All services are provided to refugee clients at either these local offices or at other local offices which are more convenient to clients.

The federal government provides additional reimbursement to the Department for cash or medical assistance provided to or on behalf of some of the cases that are eligible for the Refugee Resettlement Program. Refugees who meet the basic, financial, and categorical requirements of the SSI-related or AFDC-related categories of Medical Assistance may participate in RRP for a 12-month period (RRP/MA), beginning with the first month in which they enter the United States or, for Cuban/Haitians, the month of release from detention. Refugees who meet the basic and financial requirements but do not meet the categorical requirements of a Medical Assistance program are eligible for RRP/Non-MA for a 12-month period beginning with the month they entered the United States or, for Cuban/Haitians, the month in which they were released from detention.

4805: Local Office Responsibilities

The local office that serves the community in which the refugee resides is responsible for meeting emergency needs and providing referrals to the welfare office which services refugee clients for that service area.

If any written communications are not available in the primary language of a refugee, an RRP/MLN (multi-lingual card) shall be enclosed with the English version.

For MA-Only cases those responsibilities are:

## A. Applications

Mail-in applications

If an application is mailed to a local office and it can be determined that the applicant is a refugee, the local office director or his designee shall mail the application to the Refugee Supervisor at

the designated welfare office and inform the applicant in writing that this has been done, including the Supervisor's name, office address and telephone number. The application shall be date stamped when received and mailed to the Refugee Supervisor on the same day. The same timeliness standards apply to these cases as in all MA only cases.

#### Walk-in applications

If an applicant at a local office indicates that he is a refugee, the local office director or his designee shall:

- . review any documentation regarding refugee status that the applicant may have with him;
- . if the applicant does not have any documentation with him, inquire as to the country of origin and date of entry into the U.S.; and
- . if the applicant meets the basic requirements for RRP, determine whether a temporary MassHealth card is needed.

If no temporary MassHealth card is required, give the refugee an application and an NTP and advise the client to mail the application to the designated welfare office. If the client wants an appointment, call the Refugee Supervisor at the designated office to schedule an appointment with the client.

If a temporary MassHealth card is needed and the applicant is eligible, the local office shall:

- . issue the temporary MassHealth card;
- . telephone the designated welfare office and give the Refugee Supervisor or designee the information necessary to open the case on the system to insure that the medical bills incurred during the temporary MassHealth period are paid; and
- . send file copies of all documents to the Refugee Supervisor.

#### B. Ongoing Cases

##### Replacement of MassHealth Cards

Should a refugee client, in order to receive immediate medical care, need to have a MassHealth card replaced because of loss or theft, or because the card was inaccurately produced, provide the client with a temporary card and the Refugee Case Manager(RCM) with all necessary information to process a replacement card. If the client has no immediate medical need, refer the client to his or her RCM at the appropriate local office providing services to refugee clients and assist in providing any information the RCM may need for the prompt processing of a replacement card.



4810: Definition of Refugee Status

Refugees are aliens who are unwilling or unable to return to their country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular group, or political opinion. Aliens who are lawfully admitted or paroled into the United States are issued an immigration document which identifies their refugee status. To qualify for RRP, the refugee must provide one of the documents listed in Section 503.200(C) of the MA Policy Manual.

4811: Basic Requirements

Refugees applying for Medical Assistance must verify their entrant status by producing one of the documents listed in Section 503.200(C) of the MA Policy Manual. If they are unable to do so, they are ineligible to receive assistance under the Refugee Resettlement Program. Such persons may apply for Medical Assistance under categories 5, 6, 7, or 8.

Participation in RRP is limited to the 12-month period beginning with the month the refugee entered the United States or, for Cuban/ Haitians, the date entrant status was granted. The date of entry must be verified and may be found on the lower portion of the I-94. If the I-94 is unavailable, the applicant may submit a letter or other documentation from the Immigration and Naturalization Service containing this information. The month in which the date falls is the refugee's first month in the country. It is also the first calendar month that is counted toward the 12-month eligibility period. (A person granted entrant status on any day in June, 1989, would have to be terminated from assistance under RRP on May 31, 1990, the end of the 12-month period.) Persons who have been in the country more than 12 months are ineligible for RRP. They may apply for Medical Assistance under categories 5, 6, 7, or 8.

Refugees must also be residents of Massachusetts and must verify their residence in accordance with 106 CMR 503.100.

4815: Categorical Requirements

A refugee who meets the categorical requirements of the MA/21, MA/AFDC, MA/DA or MA/OAA programs may receive RRP/MA for a 12-month period beginning with the month he or she entered the United States or gained entrant status. At the time of application, make a determination of the refugee's categorical eligibility.

Families applying for MA/AFDC must establish that the child is deprived of the care and support of at least one parent through death, continued absence, incapacity, or the unemployment of the principal earner. A pregnant woman may establish eligibility without meeting any of these deprivation factors.

In situations of deprivation due to the death of a parent, or parents, verification may not be obtainable. If the death occurred outside of the United States and the refugee is unable to obtain acceptable verification in accordance with 106 CMR 504.410 you may accept an affidavit stating that the parent is deceased. The affidavit must contain the following information:

- . name of deceased;
- . relationship to child(ren);
- . date of death; and
- . country in which death occurred.

Unemployment or underemployment of the principal earner may be difficult to verify due to a work history that occurred outside of the country or in a refugee camp. If the principal earner is unable to provide the necessary verifications, make an eligibility determination based on available evidence and an affidavit of the work history. The affidavit must contain the following information:

- . name of principal earner;
- . place of employment;
- . dates of employment;
- . amount earned (closest American dollar equivalent); and
- . efforts made to obtain the verification.

A refugee who is disabled or age 65 or over should be advised about his potential eligibility for SSI. If the individual chooses to apply for SSI, inform him that the Social Security Administration may require verification of age, identity, and refugee status, but that application for SSI is not a condition of eligibility for Medical Assistance.

For individuals not meeting the categorical requirements of a Medicaid program, eligibility under RRP/Non-MA may be established for the 12-month period beginning with the date of entry or the date entrant status was granted.



4820: Determining the Filing Unit and the Assistance Unit

If the refugee establishes categorical eligibility, determine the filing unit and the assistance unit in the same manner as other Medicaid cases, regardless of the number of months the refugee has been in the country (see 4140). If no categorical eligibility exists, use the following general procedures in determining the composition of the filing unit:

1. Each childless unmarried adult age 18 or over or emancipated minor is a filing unit.
2. Each married couple having no dependent children is a filing unit.
3. Dependent children under the age of 18 and their parents or adult caretakers are a filing unit. (Children born in the United States are American citizens. They are granted refugee status if they are members of a filing unit in which one or both parents are refugees.)

4821: Sponsorship

Resettlement of refugees is usually handled by a voluntary agency or Volag which then gives continuing responsibility for the refugees to a local affiliated agency or sponsor. The Refugee Case Manager must notify the Volag or local voluntary affiliate that the refugee(s) has applied for Medical Assistance.

The sponsor may be an individual, a church, a civic organization, or other local group. The responsibilities of the sponsor include receiving refugees from the resettlement agency; providing initial shelter, food, clothing and pocket money for the first 30 days in the country; providing assistance in finding employment; assisting refugees in locating permanent housing; and, in general, helping refugees adjust to a new culture.

4822: Financial Requirements

Applicants and recipients of RRP are allowed the same income standards and asset limitations as other MA filing units. The Medical Assistance program treats income and assets differently depending upon the category under which persons are being aided. Refugees who are disabled or age 65 or over are given the same income deductions and asset exemptions as are those applying for categories 5 and 7. Refugees who establish a categorical relationship to categories 6 and 8 are allowed the AFDC-related income deductions and asset exemptions. Refugees who have been in the country less than 12 months and are not categorically eligible have their financial eligibility determined by using MA/AFDC standards.

All contributions from the refugee's sponsor are countable as income. Assets and income remaining in the country of exile are noncountable.

The \$30 and one-third disregards may be applied in accordance with Section 6126 if an individual or family is terminated from cash assistance under the AFDC component of RRP (that is, persons who are categorically related to AFDC). Those terminated from the non-AFDC component are not entitled to the \$30 and one-third earned income disregards. (Persons receiving cash assistance under the non-AFDC component have not satisfied any categorical eligibility requirements.)

EXAMPLE #1:

65-year-old Jorge Gomes and his 28-year-old cousin, Manuel, were both paroled into the United States as refugees two months ago. They share the same apartment and support themselves working part time as parking lot attendants. Manuel and Jorge have no other income. Their sponsor suggests they apply for Medical Assistance.

Jorge and Manuel are each childless, unmarried adults. Each one is the sole member of both his filing unit and assistance unit.

Jorge, by virtue of his age, is categorically related to SSI. In determining his eligibility for Medical Assistance, PACES will use the standard earned income deductions allowed an SSI related filing unit (See 6127).

Since Manuel is not categorically related to any Medical Assistance program, PACES will use the work-related expense deductions allowed in an AFDC-related filing unit in determining Manuel's eligibility for RRP. He would be eligible for Medical Assistance for only 12 months from his date of entry into the country.

EXAMPLE #2:

Carlos Montoya, his wife, Felicia, and their seven-year-old son were paroled into the United States 13 months ago. They received cash assistance under the AFDC component of RRP for the last two months while Carlos recovered from a broken ankle. Carlos is returning to work, and the family's cash assistance is being terminated. He is not entitled to an extension of Medical Assistance benefits because he has not received cash assistance during three of the past six months. However, the system establishes an MA/AFDC case for the family.

The Montoyas have been in the United States more than 12 months, therefore, upon redetermination, determine if the family meets categorical eligibility requirements. Because Carlos is employed full-time, there is no deprivation factor to establish continued eligibility for MA/AFDC. Since Carlos and Felicia are both over 21, only the Montoya child establishes a categorical relationship to the MA/21 program. Close the MA/AFDC case and establish an MA/21 case for the child.

The filing unit consists of three people (Carlos, his wife and child). The assistance unit is comprised solely of the child.

In determining the family's financial eligibility, PACES will use the AFDC-related income deductions.

4825: Verification Problems

Refugees may have difficulty in obtaining documentation of factors such as age or marital status. In the absence of the preferred sources of verification, the Form I-94 or other documentation from the Immigration and Naturalization Service is acceptable. If the refugee is unable to provide verification of his claim, the Refugee Case Manager may accept the refugee's written statement provided the statement is not unreasonable or contradicted by other evidence. A sponsor may also provide a written statement in support of the refugee's claim.

4830: Unaccompanied Minors

Refugee children who are unaccompanied by a parent or other adult relative are in the custody of the Department of Social Services (DSS). DSS may provide services to these children until the month after their 18th birthday. DSS places these children in foster care through private agencies. Medical Assistance is provided as for other foster children.

4840: Systems and Monitoring Procedures

When establishing a refugee case on the Recipient Master File, code the TD properly to ensure the Department receives maximum reimbursement from the Federal Government. (See PACES User's Guide.) Monitor ongoing cases carefully to ensure that termination from RRP takes place after 12 months by referring to the monthly PAL listings of RRP cases which need to be reviewed.



4841: Establishing the Case on the Recipient Master File

Families and individuals who are eligible to receive Medical Assistance under the Refugee Resettlement Program are aided under category 0.

Enter the refugee's date of entry into the United States, and the appropriate codes for the resettlement agency and the country of origin in the refugee section of the PACES T.D.

You can find the date of entry or, for Cuban/Haitians, the date entrant status was granted and the country of origin on the I-94 or the Alien Registration Receipt Card.

You can obtain the name of the resettlement agency from the sponsor if the refugee is unable to provide this information.

RESETTLEMENT AGENCY AND COUNTRY OF ORIGIN CODES

<u>Resettlement Agency Codes</u>	<u>Country of Origin Codes</u>
01 United States Catholic Conference	01 Vietnam
02 International Rescue Committee (International Institute)	02 Laos
03 Church World Service	03 Cambodia
04 Lutheran Immigration and Refugee Services	04 Haiti
05 United (HIAS) Hebrew Immigration Aid Society	05 Cuba
06 Tolstoy Foundation Inc.	06 Russia
07 American Council for Nationalities Service	07 Afghanistan
08 American Fund for Czechoslovakian Refugees	08 Ethiopia
09 World Relief	09 Chile
10 Buddhist Council for Refugee Rescue	10 Argentina
11 Travelers Aid International Social Services	11 Thailand
12 National Council of YMCA	12 Singapore
13 Other Minor Resettlement Agencies	13 Austria
14 Individual Sponsorship	14 Indonesia
15 No Sponsor - Initial Resettlement-Massachusetts	15 Philippines
16 No Sponsor - Secondary Migration From Other Part of U.S.	16 China
17 Episcopal Migration Ministries	17 Romania
	18 Czechoslovakia
	19 Iraq
	20 Pakistan
	21 Korea
	22 Poland
	23 Bulgaria
	24 Hungary
	25 Sudan
	26 Iran
	27 Zaire
	28 Yugoslavia
	29 Malaya
	30 Albania
	31 Other

4842: Monitoring Refugee Cases

Refugee cases which need to be reviewed are listed on the monthly PAL report.

Assistance units which do not meet the categorical eligibility requirements of any Medicaid program must be terminated from category 0 at the end of their 12th month in the country or, for Cuban/Haitians, 12 months after entrant status was granted. If all persons in the assistance unit reach the 12 months simultaneously, the entire case is closed. If members of the same assistance unit entered the country on different dates, each individual is deleted from the case at the end of his 12th month in the country. A person must be terminated whenever he ceases to meet the basic and financial requirements of the Medicaid program.

Refugees who have established a categorical relationship to a Medical Assistance program must be terminated from RRP at the end of their 12th month in the country or, for Cuban/Haitians, 12 months after entrant status was granted, or at an earlier date if the categorical eligibility ceases. If all persons in the assistance unit entered the country at the same time, the entire case is closed. Complete a PACES TD and Worksheet establishing the assistance unit under categories 5, 6, 7, or 8. If members of the same assistance unit entered the country on different dates, delete each individual from the assistance unit at the end of his 12th month in the country. Complete a PACES TD and Worksheet establishing an MA case for the deleted person(s) on category 5, 6, 7, or 8. (If the grantee is removed from an RRP case that is categorically related to AFDC, complete a TD under category 6.) The financial responsibility of spouse for spouse and parent for child must be considered in accordance with policy as set forth in 106 CMR 505.400-505.450.

4843: Termination Procedures

When taking action to close the RRP case or reduce the number of members in the assistance unit, advance notice of adverse action must be sent. (See PACES User's Guide for information about coding and TD completion.)



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5000: OVERVIEW OF FINANCIAL REQUIREMENTS

Chapter 5000 of the Procedures Handbook corresponds to 106 CMR 505.000-505.999 of the Medical Assistance Policy Manual. The policies and procedures of these chapters provide the worker with information on assets and income as follows.

Asset Information: Sections 5100 - 5199 provide instructions for determining:

- A. The asset limitation for the filing unit;
- B. The total value of countable assets for the filing unit; and
- C. Eligibility of the filing unit on the basis of assets.

Income Information: Sections 5200 - 5299 provide instructions for determining:

- A. the total gross income;
- B. the allowable expenses and deductions for each category of assistance; and
- C. net MA countable income.

Financial Responsibility

Sections 5400 -5499 provide instructions for determining whose assets and income are considered in making the above determinations and the extent of the responsibility. When eligibility on the basis of assets has been established and a gross monthly income figure has been determined, the worker is prepared to make a calculation of income eligibility. The information necessary to determine income eligibility, deductions and the MA income standard are provided in Chapter 6000: Calculation of Financial Eligibility.





5100: Assets

All assets are countable in calculating the amount available to a filing unit unless they are specifically exempted. See 106 CMR 505.160 for a description of typical countable assets, and 106 CMR 505.170 for a list of noncountable assets.

5101: Type and Condition of an Asset

This section presents guidelines for identifying the countable amount of an asset for the purposes of determining Medicaid eligibility. Each asset that an applicant or recipient owns must be categorized as countable or noncountable. The type of asset in most instances will determine whether it is countable or noncountable. In some cases, however, the "condition" of the asset must be assessed. Conditions that modify the value or countability of assets are:

- A. transference;
- B. assignment;
- C. joint ownership; and
- D. inaccessibility.

EXAMPLE: Type and Condition of an Asset

A filing unit owns an automobile with an equity value of \$3,200. (Further details about the ownership of this automobile are indicated below).

If the automobile is the only vehicle owned by the filing unit, it is noncountable.

If the automobile is the second vehicle of the filing unit, its countable value is \$3,200.

If ownership of the second vehicle was transferred by a noninstitutionalized person in the two-year period prior to April 1, 1990 for purposes of establishing Medicaid eligibility, its countable value is \$3,200.

If the vehicle was inherited by a recipient who already owned an automobile, it is countable.

If the second vehicle is jointly owned by the applicant or recipient and a second party, part of the equity value is countable.

If the automobile is being held by the court pending a property settlement, it is considered inaccessible until the date of the court hearing. If the court gives the automobile to someone other than the applicant or recipient, it is no longer considered in determining eligibility.



5120: Transfer of Assets

An applicant for or recipient of community medical services may assign or transfer assets on or after April 1, 1990 for any reason without a penalty.

The transfer of assets policy at 106 CMR 505.120 applies to the transfer of all countable assets at less than fair market value prior to April 1, 1990. The date, April 1, 1990, is relevant to the transfer of assets, not to the application date for Medicaid. Therefore, that policy is in effect through March 31, 1992.

An applicant or recipient who has assigned or transferred assets prior to April 1, 1990 for the purpose of obtaining or maintaining eligibility for Medicaid shall be ineligible for all Medicaid services until:

- . he or she incurs medical bills for which he or she is responsible equal to the countable value of the transferred asset; or
- . 24 months have elapsed since the month of transfer. The period of ineligibility may be waived for persons who would suffer undue hardship because of the application of this provision. (See 106 CMR 505.120 (E).)

5121: Identifying Transfers of Assets

Be on the alert to determine if a transfer of assets has taken place. The following situations might require further inquiry.

- A. The applicant or recipient states on the application that assets have been transferred.
- B. A telephone conversation or face-to-face interview with the applicant or recipient or his or her representative elicits the information that assets have been transferred.
- C. A bank book shows a large withdrawal of funds within the past two years.
- D. You are shown a new bank book with a recent deposit just within the eligibility limits and very little other activity (in such cases, ask to see the previous bank book or other source of the deposit.)

This is not meant to be a complete list.

Many clues can be obtained from an application or redetermination that appears to be inconsistent.



5122: Determination of Intent in Transfers by Applicants/Recipients

The Department's determination of intent is based upon whether the applicant/recipient retained sufficient resources (income and assets) after transfer to provide for his support and individual care based upon his age, health and life expectancy; and if not, whether the applicant had prior knowledge of the requirements of the Medical Assistance Program.

Questions to Be Asked When Determining Intent

There will always be cases involving transfers of assets in which there is disagreement and in which appeals will be filed; however, by focusing closely on intent and on circumstances at the time of transfer, such cases can be kept to a minimum. The following are some of the questions that should be asked if there has been a transfer of assets within 2 years prior to the application/redetermination. Varying circumstances will suggest others.

- A. What was the reason for the transfer?
- B. Why was it made at that particular time?
- C. Was the applicant/recipient in relatively good health for his age, or was he in a hospital awaiting nursing home placement?
- D. Does the applicant/recipient carry a life insurance policy large enough to cover funeral expenses?
- E. Had the applicant/recipient made a previous application for MA and been denied because of excess assets?
- F. If so, is the applicant/recipient not declaring assets that were listed on a previous application?

## EXAMPLE - Determination of Intent

Mr. B lives with his daughter and son-in-law, contributing a portion of his pension check for household expenses. He has a life insurance policy that will cover his funeral expenses. He has Medicare and also pays Medex premiums quarterly. He had no recent hospitalizations. He gives his daughter and son-in-law \$10,000 to help build an extension on their house. Two months later Mr. B has a bad fall, breaks his hip and is hospitalized. Nursing Home care seems indicated, and he applies for MA.

There was no indication that he expected to need MA. Therefore the transfer of the \$10,000 does not appear to have been for the purpose of rendering himself eligible.



5123: Transfer Not Affecting Eligibility

THERE IS NO INTENT TO RENDER ONESELF ELIGIBLE FOR MA AND THEREFORE THE TRANSFER DOES NOT AFFECT ELIGIBILITY WHEN:	EXAMPLE	REASON FOR WORKER'S DECISION
the total countable assets, including the value of the transferred property, is equal to or less than the allowable asset for the family size.	Mr. H is single. He has \$900 in savings bonds. Prior to making his application for MA, Mr. H gives the bonds to his nephew.	Because Mr. H's allowable asset limit is \$2,000, this transfer does not affect his eligibility.
the transferred asset is an exempt asset that would not have rendered the applicant/recipient ineligible for MA if it had been retained.	Mrs. E who is widowed, has just suffered a stroke. She has \$1,200 in a savings account, \$650 in a checking account, and a four-year old car. She gives the car to her son just before applying for MA.	Since the car is exempt, and the total value of her countable assets is below \$2,000, Mrs. E would have been eligible even if she still owned the car. The transfer does not affect her eligibility.
<p>the applicant/recipient received adequate consideration for the value of the property transferred. Adequate consideration includes:</p> <ul style="list-style-type: none"> <li>a transfer made to satisfy a legally enforceable debt; and (continued on next page)</li> </ul>	Mr. G and his wife have a joint savings account of \$5,500. Mr. G also has an outstanding bank loan of \$3,000 which he repays prior to applying for MA.	The \$2,500 remaining is within eligibility limits, and because this was a legally enforceable debt, the transfer does not affect eligibility. In such a case, however, the worker should ask to see and copy the actual bill(s) or loan agreement.

Continued on next page

THERE IS NO INTENT TO RENDER ONESELF ELIGIBLE FOR MA AND THEREFORE THE TRANSFER DOES NOT AFFECT ELIGIBILITY WHEN:	EXAMPLE	REASON FOR WORKER'S DECISION
a transfer made to reimburse someone other than a legally responsible person for care or benefits provided on the understanding that reimbursement would be made.	Mrs. N is in her seventies, and disabled. Her friend Mrs. T helps her clean and cook. Mrs. N. has promised Mrs. T that she will be reimbursed in her will. Mrs. N. is no longer able to remain in her home. Before applying for MA, Mrs. N. transfers \$2,000 from her \$3,000 bank account to Mrs. T.	There had been an understanding that Mrs. T would be reimbursed in some way for her services. There was adequate consideration for the transfer and this transfer does not affect Mrs. N's eligibility.
the applicant/recipient received fair market value for the asset.	Three months before Mr. M applied for MA he sold his second car. Mr. M received an amount for the sale that exceeded the amount listed in the Vehicle Valuation Book.	Because Mr. M received fair market value for the vehicle, there was no intent to render himself eligible.
the funds transferred went to a burial account.	One year before applying for MA, Mrs. F withdrew \$2000 from her savings account and opened an account to cover her burial expenses.	Because Mrs. F transferred the funds into a separate burial account and has made no withdrawals from the account there was no intent to render herself eligible.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

5124-1

## 5124: Transfer Affecting Eligibility

THERE SEEMS TO BE INTENT TO RENDER ONESELF ELIGIBLE FOR MA WHEN:	EXAMPLE	REASON FOR WORKER'S DECISION
the applicant/recipient did not retain sufficient resources (income and assets) to provide for his support and medical care, judged on the basis of his age, living arrangements, and medical condition.	Mr. C who is in the hospital awaiting nursing home placement, transfers \$10,000 to his daughter and son-in-law.	Although this may also be used for an extension to their house, as in the example of Mr. B in Section 5122, the timing is far different. Mr. C knows he will need extensive medical care, and he has intentionally divested himself of the means to pay for it.
the applicant/recipient had prior knowledge of the MA Program, including asset eligibility and transfer of assets regulations.	Mr. S, who has recently suffered a stroke and is in the hospital, had applied for MA in late February. His application was denied because he had a \$2,000 life insurance policy with a cash surrender value of \$1,600, plus a savings account of \$4,000. On March 1, Mr. S took \$3,600 from the bank and gave it to his son.	It would seem, because of his prior knowledge of the MA program, that he intentionally transferred an asset and that the transfer was made for the purpose of rendering himself eligible for MA.
the applicant's/recipient's countable assets including the value of the property transferred exceeds the allowable asset limit; and  the applicant/recipient did not receive adequate consideration for the value of the property transferred.	Mrs. D owns the home in which she lives and the house next door. Prior to the application she transfers the house next door to her daughter for \$1.00.	Ownership of a second house would have made her ineligible for MA. Mrs. D did not receive adequate consideration for the transfer.

Continued on next page

THERE SEEMS TO BE INTENT TO RENDER ONESELF ELIGIBLE FOR MA WHEN:	EXAMPLE	REASON FOR WORKER'S DECISION
the transfer was in payment for a nonlegally enforceable debt.	Mr. Q explains a \$5,000 withdrawal from his bank account shortly before his application for MA by telling the worker he had lost the money gambling and has to pay his debts.	Gambling debts are not legally enforceable and Mr. Q would not be eligible.  NOTE: There are other debts that are not enforceable; some, but not all, contracts must be in writing. (If there is a question about the legality of a debt, the local office director or designee should ask Central Office for an opinion). If the Hotline cannot answer the question, they will consult with the Legal Division.
the transfer was made to a legally responsible person for care or services provided by the legally responsible person.	Mrs. R. tells the worker who questions a withdrawal from her savings account, "My husband has taken me shopping and to doctors' appointments and helped me out in many other ways during the past few years when I have been in poor health. I paid him \$6,000 for his time."	Mr. R is legally responsible for his wife and such a transfer is not allowed.  NOTE: If this transfer had been made to a non-legally responsible person, such as a child, the worker would have to investigate the adequate consideration factor and request evidence such as statements from disinterested third parties that the claimed services had actually been performed.





## 5125: Transfer of Assets - Institutionalized Persons, Effective April 1, 1990

The spousal impoverishment policy at 106 CMR 505.180 takes precedence over the transfer of assets policy. Refer to the procedures in Section 5180.

The transfer of assets policy at 106 CMR 505.125 applies not only to countable assets transferred for less than fair market value but to the home used as a principal residence as well.

An institutionalized applicant or recipient (or his or her spouse) who has assigned or transferred assets on or after April 1, 1990, in the preceding 30 months for the purpose of obtaining or maintaining the institutionalized individual's eligibility for Medicaid shall be ineligible for a Medicaid payment for nursing facility services from the month of the transfer until:

- . the number of months that result when the total value of the assets transferred, divided by the average monthly cost of providing nursing home care in the Commonwealth at the time of the application as determined by the Department have elapsed; or
- . 30 months have elapsed.

The average private cost of nursing home care is \$100 per day. This amount will change and be updated.

### A. Identifying Transfer of Assets

Use the guidelines in Section 5121 to identify situations that suggest a transfer of assets has taken place.

### B. Exclusions

You must record and document all transfers, but in certain situations you will not deny eligibility.

1. See Section 5123 for a description of transfers that do not affect eligibility.
2. The Home Used as a Principal Place of Residence

Do not deny or terminate Medicaid when an applicant or recipient transfers a home used as a principal place of residence at the time of the transfer to one of the following:

- a. his or her spouse; or
- b. his or her child who is under 21, or who is blind or permanently and totally disabled;
- c. his or her sibling who has an equity interest in the home and was residing in the home for a period of at least one year immediately before the date of the individual's admission to the institution; or



5125: Cont.

- d. his or her child (other than the child described in b. above), who was residing in the applicant or recipient's home for a period of at least two years immediately before the date of the applicant or recipient's admission to the institution and who provided care to the applicant or recipient which permitted him or her to reside at home rather than in an institution.

You must verify residence in the home in the same way you verify residence for Medicaid eligibility. A competent medical authority must verify that the applicant or recipient could not have remained in the community without care.

C. Intent to Render Oneself Eligible for Medicaid

The applicant or recipient (or his or her spouse) must demonstrate to the Department that he or she did not transfer assets to obtain or maintain eligibility for Medicaid. You can use Sections 5122, 5123, and 5124 to help determine if this has been adequately demonstrated.

Example 1:

Mr. A applies for Medicaid on July 12, 1990. While in the hospital on May 5, Mr. A transferred \$15,000 from his bank account to his adult son. He entered a nursing home on June 4, 1990. His hospital bills were covered by Medicare and other private insurance.

Using the current \$100 per day average private nursing home rate, you determine that \$15,000 divided by \$100 = 150 days (approximately five months). Since 150 days is less than 30 months, the last day of Mr. A.'s ineligibility period is October 31, 1990.

Example 2:

Mr. B applies for Medicaid in June, 1990. He entered a nursing home in May, 1990, the same month he transferred \$180,000 in countable assets to his three adult children. Using the current \$100 per day average private nursing home rate, you determine that \$180,000 divided by \$100 = 1800 days (approximately five years). Therefore, Mr. B's ineligibility period ends 30 months from the date of the transfer, on October 31, 1992.

If you determine the individual is ineligible as a result of a transfer, the denial letter should indicate a period of ineligibility for nursing facility services. Since the transfer provision only applies to payment of nursing facility services, you should establish the case on PACES (using a community group code in Block 35 of the TD). If the individual's income is less than the applicable standards, he or she may be eligible for payment under Medicaid for ancillary services. Such individuals may also be eligible as OMB's.

5130: Asset Reduction

It is important to remember that there are two steps to eligibility for an applicant or recipient who has excess assets.

1. He or she must incur or have incurred allowable medical bills (see 6540) that equal or exceed the excess assets.

AND

2. He or she must reduce the assets to the allowable limit within 30 days from the date of the Potential Eligibility Notice.

Eligibility Date

The date of eligibility is the date on which the existing excess asset amount is equal to the incurred medical bills. If the applicant has incurred enough medical bills but has not reduced his assets, then he or she is not eligible for Medicaid until the assets are reduced. Once reduced, the date of eligibility goes back to the date when the bills met the excess amount. The Department is not responsible for the medical bills used to meet the excess asset amount.

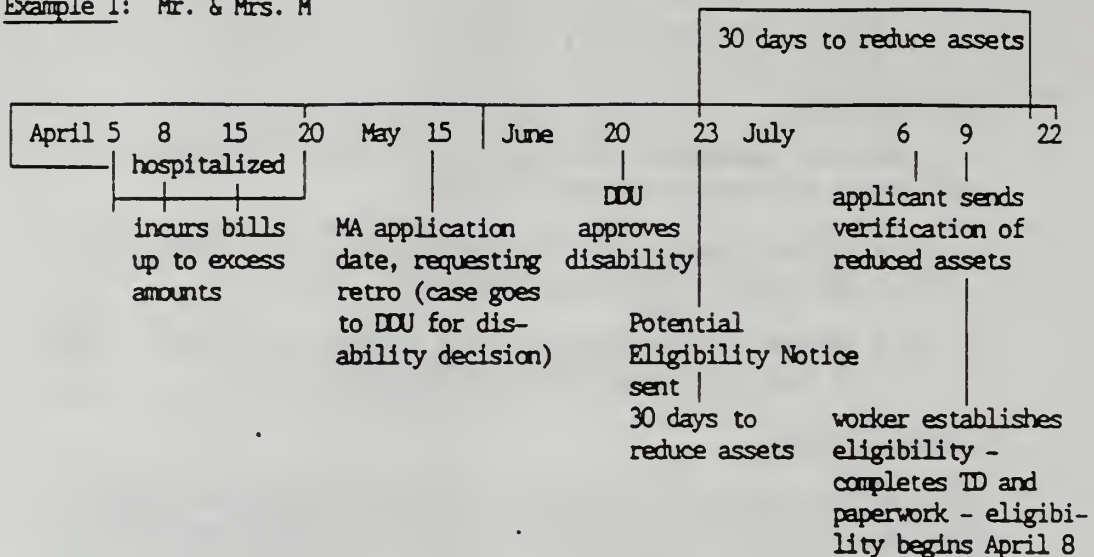
If the applicant later brings in an allowable bill from an earlier date, you must adjust the date on the TD. This can include the three-month retroactive period, if the applicant is otherwise eligible. If the applicant has both excess income and excess assets, the six-month excess income period begins on the date the excess assets equal the incurred medical bills and extends through the end of the subsequent five calendar month period.

Example 1:

Mrs. M. is hospitalized from April 5 to April 20. She mails in an application for MA/DA on May 15th, including the application for retroactive assistance. Mrs. M. and her husband's countable assets consist of \$7500 in the bank. Mr. M. is employed, but Mrs. M received her last pay check in February.

The worker submits the case to the disability determination unit (DDU). When Mrs. M.'s disability is approved by DDU on June 20, the worker computes the excess assets and excess income, and sends the Potential Eligibility Notice, the worksheets, and the brochure explaining excess assets and income to Mrs. M. on June 23. (After determining if an applicant meets the asset limit, you must also do a determination of income eligibility, so that the applicant receives a complete picture of his or her financial eligibility on the notice.)

Mrs. M. submits her and her husband's medical bills. They have bills totaling the excess asset amount by April 8. On April 15, they have additional bills that meet the excess income amount. They reduce their assets and mail in their bank statement on July 6. On July 9, the worker completes a TD to establish Mrs. M's MA/DA case effective April 8.

Example 1: Mr. & Mrs. MSubmitting PA-37's

Once an applicant with excess assets establishes eligibility, you must complete a PA-37 and submit copies of medical bills used to meet the excess to the MMIS Claims Resolution Unit in accordance with instructions on the back of the form. Indicate on the PA-37 that the applicable bills are being used to meet an excess asset amount. If the applicant has excess income as well, indicate on the PA-37 those bills that are being used to meet excess assets and those that are being used to meet excess income.

Burial Funds (See 5171)

You must inform applicants and recipients they cannot reduce their countable assets by giving them away, and you must inform them of the penalties for transfer. You must also inform them about exempt burial funds and other exempt assets.

Only burial accounts that were in existence on the date of application can be considered to have been in existence for the three-month retroactive period. If such accounts are set up after the date of application, they satisfy the asset reduction requirement, but they do not reduce the amount of excess assets for the retroactive period.

Even though the applicant may reduce assets by purchase of an exempt burial fund or other exempt assets, the Department nonetheless is not responsible for the medical bills used to meet the excess asset amount.

Example 2:

On July 5, Mr. D. applies for retroactive Medicaid effective April 7. His assets are stocks worth \$4200, \$1500 in the bank, and a \$2200 burial fund which he established on July 1. His combined countable assets total \$5700, making his excess assets \$3700. (Had he applied prior to July 1, the \$2200 would have been counted toward his total excess assets.)



Mr. D receives his Potential Eligibility Notice on July 18. On August 2, Mr. D has reduced his assets to \$1900. He had incurred medical bills of \$4000 by June 12, his date of Medicaid eligibility.

NOTE: The value of Mr. D's stocks was \$3500 in April, rose to \$5200 in June and fell to \$4200 in July. Since stocks may fluctuate in value, use the value of the stocks as of the date of application for Medicaid to determine the amount of excess assets. However, when the stocks are being liquidated, count only their value on the date of disposal to meet the asset limit.

Example 2: Mr. D

April 7—requested retro period	May	June 12 incurs medical bills of \$4000  12	July 5 — MA Application  18 — Potential Eligibility Notice sent	August  17 last day to reduce assets  2 reduces assets and verifies 2 eligibility approved with retro to 6/12
			Assets July 5: Stocks \$4200 Bank 1500 5700 -2000 asset limit \$3700 excess	





5150: Inaccessible Assets

There are a number of reasons that might prevent an applicant or recipient from selling, converting or otherwise disposing of his own property.

If a person's physical or mental ability prevents taking action, verification of the disability from a competent medical authority must be obtained.

Other situations are more difficult to deal with, especially when lack of needed cooperation by a third party may create inaccessibility of an asset. A person may own a joint bank account, but the co-holder may have the bank book. Although banking regulations provide for a person to withdraw funds without his passbook, the procedures vary among banks, and an applicant or recipient may be refused access.

In this situation, the worker must contact the bank to ask what the person must do to obtain access and must inform the applicant or recipient accordingly. If the bank does not allow the applicant or recipient access to the account, it is considered inaccessible until the individual is able to obtain the bank book.

An applicant or recipient may jointly own a piece of property and the co-owner may refuse to sell or buy him out. The applicant or recipient must show the worker the title, deed, or whatever proves dual ownership, or must show that he cannot provide this verification, because of circumstances beyond his control. The worker must then be sure that dual authorization is required. If it is, and the applicant or recipient claims that the co-owner will not put his intentions in writing, then the worker must write to the broker, lawyer, or co-owner himself if there is no other alternative. If the third party fails to respond or refuses to cooperate, the worker must determine if legal action can be taken. If no legal action is possible, or while legal action is pending, the asset is inaccessible.

Anytime there is a reasonable effort on the part of an applicant or recipient to reduce his assets, and circumstances beyond his control prevent it, the worker must help him gain access or prove he cannot. If he cannot gain access, the asset is inaccessible.

Temporary Inaccessibility

In some instances there will be a change in the circumstances that caused an asset to be determined inaccessible for eligibility purposes. For example, the individual is no longer disabled, or a divorce case is settled. The worker must review these circumstances at redetermination, and keep a tickler file if it appears that they will change before the redetermination is due.



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

5160-1

## 5160: Countable Assets

**Introduction** This section is intended to assist the worker when determining the eligibility impact of an assistance unit's assets.

**Manual** Consult the following sections in the Manual for the policy  
**References** regarding assets.

Definition	501.500(E)
Eligibility Limitation	505.110
List of Countable Assets	505.160
List of Noncountable Assets	505.170
Ownership of Assets	505.140
Inaccessible Assets	505.150
Transfer of Assets	505.120

### Asset Eligibility Test

The asset eligibility test is performed by the worker using the following steps.

Step	Action						
1	Determine the value of each countable asset owned by or available to each member of the filing unit.						
2	Total the values of all countable assets as determined in Step 1.						
3	Determine the asset limit for the number of persons in the filing unit (See 106 CMR 505.110.)						
4	<p>Compare the asset limit (Step 3) with the total value of the countable assets (Step 2).</p> <table> <tr> <td>If the total value of the countable assets is....</td><td>Then the filing unit...</td></tr> <tr> <td>equal to or less than the asset limit</td><td>meets the asset eligibility requirement.</td></tr> <tr> <td>greater than the asset limit</td><td>is ineligible.</td></tr> </table>	If the total value of the countable assets is....	Then the filing unit...	equal to or less than the asset limit	meets the asset eligibility requirement.	greater than the asset limit	is ineligible.
If the total value of the countable assets is....	Then the filing unit...						
equal to or less than the asset limit	meets the asset eligibility requirement.						
greater than the asset limit	is ineligible.						

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

5160-2

Example  
of Asset  
Test

Sarah Spencer has made an application for herself, her husband, and two children. The assets of the filing unit are a savings account of \$3,000; Sarah's diamond necklace valued at \$500; a checking account of \$200 and a sterling silver punch bowl valued at \$900.

Step	Action
1	<p>Determine the value of each countable asset owned by or available to each member of the filing unit.</p> <p>Savings Account - \$3000  Diamond Necklace - \$0 (noncountable)  Checking Account - \$200  Punch Bowl - \$0 (noncountable)</p>
2	<p>Total the values of all countable assets as determined in Step 1.</p> <p>Savings Account - \$3000  Checking Account - +200  TOTAL \$3200</p>
3	<p>Determine the asset limit for the number of persons in the filing unit.</p> <p>\$3000 Mr. and Mrs. Spencer  100 first child  100 second child  \$3200 Asset limit for a filing unit of 4</p>
4	<p>Compare the asset limit (Step 3) with the total value of the countable assets.</p> <p>The total value of the countable assets (\$3200) is equal to the asset limit (\$3200). Therefore the filing unit meets the asset eligibility requirement.</p>

NOTE: The amount of assets may equal the amount of the asset limitation but may not exceed this amount. The applicant should be told that she will exceed the asset limitation as soon as interest on the bank account is accrued this month.

## MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

5160-3

ASSET	WHEN TO VERIFY	HOW TO VERIFY
CASH ON HAND	<ul style="list-style-type: none"> <li>• application</li> <li>• redetermination</li> <li>• at time of reported change</li> </ul>	<ul style="list-style-type: none"> <li>• client's declaration on application/redetermination form</li> </ul>
BANK DEPOSITS	<ul style="list-style-type: none"> <li>• application</li> <li>• redetermination-(at alternate eligibility determinations for accounts, other than checking accounts with balances of \$25 or less)</li> <li>• at times of reported change</li> </ul>	<ul style="list-style-type: none"> <li>• bank books or bank statements showing the bank balance within 45 days of the date of application or date the redetermination form is received in the local office</li> </ul>
IRA'S, KEOGH'S, OR PENSIONS  (gross amount less penalty for early withdrawal)	<ul style="list-style-type: none"> <li>• application</li> <li>• redetermination</li> <li>• at time of reported change</li> </ul>	<ul style="list-style-type: none"> <li>• written statement from bank or former employer dated within 45 days of the date of application or date the redetermination form is received in the local office</li> </ul>
SECURITIES	<ul style="list-style-type: none"> <li>• application</li> <li>• redetermination</li> <li>• at time of reported change</li> </ul>	<ul style="list-style-type: none"> <li>• statement from an individual, corporation, licensed stockbroker, bank or government agency issuing the security; or</li> <li>• clipping from a current daily newspaper showing the date and closing bid price; or</li> <li>• statement from a financial services institution able to verify current value; or</li> <li>• documentation from a current financial publication</li> </ul>
PERSONAL NEEDS ALLOWANCE (PNA) ACCOUNT	<ul style="list-style-type: none"> <li>• application</li> <li>• redetermination</li> <li>• at time of reported change</li> </ul>	<ul style="list-style-type: none"> <li>• written statement from bank or facility where account is maintained, dated within 45 days of the application date or date redetermination is received by local office</li> </ul>



## MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

5160-4

ASSET	WHEN TO VERIFY	HOW TO VERIFY
FAIR MARKET VALUE OF COUNT- ABLE VEHICLES	<ul style="list-style-type: none"> <li>. application</li> <li>. when another vehicle is acquired.</li> <li>. at redetermination when the vehicle's value, combined with other assets may affect eligibility</li> </ul>	<ul style="list-style-type: none"> <li>. wholesale value in most current vehicle valuation book used by the Department; or</li> <li>. low value in an older car valuation book; or</li> <li>. assigned value of \$250 if too old to appear in older car book; or</li> <li>. written appraisal of licensed automobile dealer who deals with classic, custom-made or antique vehicles, if vehicle is considered one; or</li> <li>. for recreational vehicles <ul style="list-style-type: none"> <li>- finance value in most recent vehicle valuation book used by the Department</li> <li>- projected loan value as quoted by lending institution.</li> <li>- documents showing value of vehicle for insurance purposes</li> <li>- written estimate of vehicle's value from licensed recreational vehicle dealer</li> </ul> </li> </ul> <p>NOTE: The client may rebut the Department's assigned valuation of any vehicle.</p>

ASSET	WHEN TO VERIFY	HOW TO VERIFY
CASH SURRENDER VALUE (CSV) OF LIFE INSURANCE	<ul style="list-style-type: none"> <li>• application</li> <li>• at least once a year</li> <li>• at time of reported change</li> </ul>	<ul style="list-style-type: none"> <li>• Table of Values in life insurance policy; or</li> <li>• written statement from the issuing company or its representative</li> </ul> <p>NOTE: A written statement is mandatory:</p> <ul style="list-style-type: none"> <li>• when the total CSV of all policies combined with the value of other assets is within \$150 of the asset limit; or</li> <li>• when the policy is paid up; or</li> <li>• when the policy has been in effect longer than the number of years in the table.</li> </ul>
FAIR MARKET VALUE OF REAL ESTATE OTHER THAN THE PRINCIPAL PLACE OF RESIDENCE	<ul style="list-style-type: none"> <li>• application</li> <li>• times of reported changed when it could affect eligibility</li> </ul>	<ul style="list-style-type: none"> <li>• See 106 CMR 505.160(H).</li> </ul> <p>NOTE: The client may rebut the Department's assigned valuation of any real property.</p>
RETROACTIVE SSI AND RSDI BENEFIT PAYMENTS	<ul style="list-style-type: none"> <li>• at time of receipt</li> </ul>	<ul style="list-style-type: none"> <li>• notification letter from the Social Security Administration</li> </ul>

5161: Bank Deposits and Retirement Accounts

Identification of Potential Accounts Bank deposits will sometimes require exploration by the worker. Potential questions may be raised by a review of the application or during the process of eligibility determination. If available information is inconsistent or circumstances indicate the possible existence of additional bank deposits, the worker should request clarification.

Circumstances That May Require Exploration Workers should consider the following.

Credit Unions or Profit Sharing Plans	In filing units with earned income or union membership a member may participate in a credit union or profit sharing plan.
Bank Where Checks are Cashed	If an applicant/recipient indicates he has no bank accounts, the worker should ask where he cashes checks. Some banks cash checks for account holders only. If the applicant/recipient cashes checks at a bank that services only account holders, he may be requested to verify that no account is held at the bank.
Mortgages	Homeowners sometimes hold checking or savings accounts at the bank where their mortgage is held.
Zero Balances	Some applicants/recipients tend not to mention open bank accounts that have little or no money in them, thinking that such accounts would not be significant. Workers should ask specifically about this point to discover underclaimed accounts.
Inconsistent Information	If the applicant's/recipient's past earnings and lifestyle seem at variance with current financial information, the worker should ask specific questions, in order to determine if there are other assets.

Types of  
Bank Accounts

The chart below lists the types of bank accounts a worker may encounter and a brief description of each.

Types	Description
Checking Account	<p>Funds held by an institution for an individual. The individual can issue a written order to the banking institution to pay an amount of money to a designated party. If the applicant/recipient claims that the balance is lower than that shown on the most recent statement because of outstanding checks, and if the difference would affect eligibility, he must verify this claim by the check register. If additional verification is necessary, bank deposits can be verified by contacting the bank with the permission of the applicant or recipient.</p> <p>NOTE: The worker must be careful not to count a direct deposit of income (i.e., a Social Security, SSI or Veteran's check) as an asset in the month received.</p>
Savings Account	Funds on which interest is paid and from which withdrawals can be made only by presentation of a passbook or written authorization on a prescribed form. Savings accounts are also funds deposited with an institution (e.g., bank, credit union) in exchange for the payment of interest on the amount of deposited funds.
Term Certificates	Term certificates are a form of earnings that discourage withdrawals of funds by an interest penalty. They are accessible to the holder, and are considered countable.
Individual Retirement Accounts	Tax laws allow an individual with earnings to open an IRA even if the individual is covered by the employer's pension or profit sharing plan. An IRA interest rate may be at a variable rate with interest changing monthly or at a fixed rate that guarantees a constant rate of return until maturity. IRA's are countable even if the owner must pay a penalty.





Verifying Degree of Joint Ownership      If an applicant/recipient states that he does not own the funds on deposit in a joint bank account to which he has access he must verify the degree of ownership in accordance with 106 CMR 505.140.

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Example 1  
Verifying Lack of Ownership      Bobby Jo Buchanan applies for MA-21 for her baby daughter, Thelma Lu. Her application indicates she has a joint savings account with her 74 year old grandfather, Billy Bob Buchanan. The current balance of the account is \$11,000.

Bobby Jo brings the passbook to the intake worker. The account is titled Bobby Jo or Billy Bob Buchanan, indicating both individuals have access to the account. Bobby Jo explains that her grandfather opened the account when he retired at age 65 and added her name to the account so that she could withdraw money as he needed it. She submits a statement from Billy Bob's physician which indicates Mr. Buchanan has rheumatoid arthritis and has a great deal of difficulty moving around. The only deposits shown on the account are the direct deposits of Billy Bob's Social Security checks on the 3rd of each month.

Although Bobby Jo has access to the money in the account, she has verified that she does not own the money. The account balance, therefore, is not counted when determining her eligibility.

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Example 2  
Verifying Partial Ownership      Lily B. Goode, a 65 year old widow, has retired from her job at the local bakery. She states on her Medicaid application that she has a joint savings account with her friend, A.K. Tumbril. The current balance of the account is \$5200.

Lily brings in a passbook titled A.K. Tumbril or Lily B. Goode. She states she has access to the entire account balance but owns only part of the money. Lily indicates the only money she holds in the account are a \$532 deposit, made in March, 1982, representing that year's income tax refund, and a \$750 deposit made in 1980 with the life insurance proceeds remaining after payment of funeral expenses for her late husband, B. Wellington Goode.

Lily explains to the intake worker that she lives rent free in Mr. Tumbril's multifamily house in exchange for managing the household's accounts. Most of the deposits, she states, represent rental income from the second and third floor tenants, while withdrawals are for business expenses.

As verification of her share of the account, Lily brings in copies of her 1982 income tax return showing a refund of \$532 due. She also brings a copy of a letter from her late husband's insurance company stating she would receive \$3550 in life insurance proceeds. She verifies the cost of the funeral by submitting a copy of the bill from the funeral home in the amount of \$2800. To verify her friend, A.K. Tumbril's share of the account, she obtains copies of the two leases showing combined rental income of \$525. (The passbook shows deposits in the amount of \$525 each month.) Lily has verified partial ownership of the account.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

5161-5

NOTE: The worker should advise Ms. Goode that, should she be determined eligible for MA, she would have to continue to submit verification of her share of the account at each redetermination. Lily must be given written notice that she has the right to set up a separate account with her share of the money without this being considered a transfer of assets. (The account must be established within 30 days of the date of the notice). See below for suggested wording of such a written notice. Should she decide to do this, Lily would have to bring in the new passbook, showing the establishment of the account in her name, as well as the original passbook showing the withdrawal of her funds and the removal of her name from the account designation.

Example -  
Joint Bank  
Account  
Letter

Following is an example of a letter a worker might send to the client regarding the joint bank account.

Date 12/16/85

Dear Ms. Goode

You have provided us information that shows your name as a joint holder on account #9999 at Benton Heights Savings Bank. You have also submitted evidence which establishes that only \$1282 of the money in this account belongs to you.

You may continue to hold your money in this account. However, if you choose to do this, you must verify the portion of the money that is yours at every future eligibility determination.

If you prefer, you may withdraw your funds from the joint account and set up a separate account that contains only your money. If you choose to do this, it will not be considered a transfer of funds to make yourself eligible for Medical Assistance provided you open the new account and submit proof of the transfer by 01/16/86. You must bring in the new passbook or other bank documents which verify that a separate account has been opened in your name, and you must also verify that your name has been removed from the joint account by the above date.

If you have questions about this notice, please contact your Financial Assistance Social Worker before you withdraw any funds from your account.

Financial Assistance Social Worker

Example 3  
Exception  
To Verifi-  
cation  
Requirements

In certain circumstances, it is not necessary to verify an account balance. Alice Horton is a recipient of MA-21. At the time of a redetermination the worker determines her only countable asset is a savings account in the amount of \$23.68.

The worker decides that Alice does not have to provide verification of this account because verification at a redetermination is not required when:

- ° the recipient states the balance is less than \$25; and
- ° the account is not a checking account; and
- ° the balance was verified at the last eligibility determination; and
- ° the balance does not affect continuing eligibility.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

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## 5162 Personal Needs Allowance Accounts

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What is a PNA? All patients in long term care facilities are entitled to a Personal Needs Allowance (PNA). In some instances the patient keeps this amount from his own income, in others, the Department pays or supplements the patient's own income monthly up to the amount currently prescribed in 106 CMR 506.420.

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PNA Account The money from the PNA, that is not spent on personal needs, must be saved for the patient to spend. When the facility is responsible for managing the funds, it is put into a PNA Account.

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Items PNA Account Cannot Be Used For The funds from this account may not be used to purchase items included in the per diem rate set by the Rate Setting Commission for the facility or allowable under the Medical Care Plan on a vendor payment basis, or allowable under Chapter 766 funds.

A partial list of items that may not be charged to the patient's Personal Needs Allowance Account appears below:

- group activities or entertainment that occurs within the facility;
  - parties organized by the facility;
  - medically necessary drugs, medicine, or medical supplies;
  - room and board at the facility;
  - wheelchair purchase, rental, or repair (other than customized or motorized wheelchairs);
  - physical restraints;
  - transportation to obtain necessary medical treatment; and
  - personal laundry (other than dry cleaning).
- 

Misuse of PNA Misuse of the PNA by an authorized representative is not an uncommon occurrence. Workers may sometimes receive a call from a nursing home administrator stating that the representative, often a relative, handling the PNA buys no clothes or other items for the patient, and they have been providing the patient with clothes belonging to patients who have died. The representative may argue that the nursing home loses all the clothes.

The worker must be careful not to become caught in the middle but can tactfully remind the representative of the purpose of the PNA without making any accusations.

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Monitoring  
PNA  
Accounts

When the portion of an individual's monthly PNA that is not spent on personal needs is allowed to accumulate in a bank account or PNA account at the facility, the PNA funds become a countable asset (income in the month received, assets thereafter). If the recipient's total countable assets, including the accumulated PNA, exceeds the asset limitation, the recipient is no longer eligible for Medical Assistance. The recipient and the representative or facility in charge of the funds should be aware of this. The worker may inform them of the dollar value of the recipient's total countable assets, and the asset limitation, and that the PNA can be spent on radios, clothing, etc. and for birthday and Christmas gifts for relatives and friends.

Example  
PNA Account  
Nearing  
Asset  
Limit

Mr. Mc had been in a chronic hospital receiving Medical Assistance for three years. During this period, part of his monthly PNA has been accumulating in an interest bearing account at the hospital. The hospital representative has submitted Mr. Mc's redetermination form, indicating that the balance of the PNA account is now \$1,440.00. Mr. Mc also has a life insurance policy with a face value of \$2,000.

Determine total countable assets and asset eligibility.

\$1,440.00	PNA Account balance
+ 360.00	Countable cash value of life insurance
<u>\$1,800.00</u>	Total countable assets

Assets do not exceed the Asset Limitation of \$2,000.00.

Review the current case situation to determine whether or not ineligibility is imminent.

\$2,000.00	Asset Limitation	\$25.00	monthly PNA account deposit
<u>-1,800.00</u>	Total countable assets	<u>+7.80</u>	approximate interest
200.00		\$32.80	

6 - months to go  
32.80 ) 200.00

The worker should inform the hospital representative that ineligibility may be imminent.



5163 Securities

To determine the countable value of securities, use the following guidelines:

Security	Description
Stocks	<p>Stocks are monies or capital invested in a corporation or business, in the form of transferable certificates. The value of a stock is determined by its demand. As a result of constant trading, the value of stocks can fluctuate from day to day. The daily paper quotes the "bid" and "asked" price of tradeable stocks. The "bid" price is the price the buyer is willing to pay for the share of stock. The "asked" price is the price the seller wants for one share of stock. For example, a share of stock may be bid at 18 1/4 (18.25) and asked at 19 (19.00). To determine the countable value of stocks, multiply the number of shares owned by the most recent bid price. If the closing bid price of a stock is not available in the paper, contact a stockbroker or trust department of a bank to verify its current bid price.</p>
Bonds	<p>A bond is a written obligation to pay a sum of money at a specified future date. It is a negotiable instrument and is transferable. The following list describes the types of bonds and the manner in which their countable values are determined.</p> <ul style="list-style-type: none"> <li>◦ <u>Municipal, Corporate, and Government Bonds.</u> The fiscal obligation of a state or locality is commonly called a "municipal bond". The term "corporate bond" denotes the bonds and debentures of private corporations. "Government Bonds", distinct from U.S. Savings Bonds, are transferable obligations issued or backed by an agency of the federal government. To redeem a municipal, corporate, or government bond for its stated value, it must be held until the specified date of maturity. The countable value of these bonds is the current fair market value less encumbrances.</li> <li>◦ <u>Series E Savings Bonds.</u> Although these are still the most commonly held bonds, Series E Savings Bonds have not been issued since 1980. The face values range from \$25 to \$10,000, and the issue prices were from \$18.75 to \$7,500. Interest accrues on E bonds and results in increased redemption (cash) value. If an E bond is retained after maturity (5 years from issue), the cash value is more than the face value. These bonds are all now redeemable. Their face value is the issue price plus accrued interest.</li> </ul>

(continued)

Security	Description
Bonds (cont.)	<ul style="list-style-type: none"> <li>° <u>Series EE Saving Bonds.</u> Series EE Savings Bonds have been issued since 5/1/81. The face values range from \$50 to \$10,000, and the issue prices range from \$25 to \$5,000. Interest accrues on EE bonds and results in increased redemption (cash) value. These bonds reach maturity eight years from the issue date, and if held after maturity, continue to accrue interest, so that the cash value is then more than the face value. The bonds may be redeemed at any time after six months from the issue date. The cash value is then the issue price plus accrued interest.</li> <li>° <u>Series H and HH Savings Bonds.</u> Series H and HH bonds have not been issued since 11/1/82, but are still held and continue to pay interest. The face values range from \$500 to \$10,000, and the issued price is the same as the face value. The redemption (cash) value of an H/HH bond never changes, as it is the same as the face value. Semi-annual interest checks are mailed to H/HH bond holders beginning six months from the issue date. <u>This would be considered income in the month received.</u> H/HH bonds may be redeemed at face value at any time after six months from the issue date.</li> </ul>
Debentures	Debentures are unsecured loans. The written agreement to repay a loan depends solely on the credit of the person being issued the certificate of indebtedness. The countable value is the amount of the debenture.
Mutual Funds and Money Market Shares	Mutual funds and money market shares are certificates or documents signifying ownership of a portion of an enterprise. The certificate or document is redeemable in cash. The fair market value of mutual funds and money market shares is the countable value.
Corporate or Promissory Notes	A promissory note is a written unconditional promise signed by the person who promises to pay a specified sum of money at a specified time, or on demand, to the person, corporation, or institution named on the note. A promissory note may be discounted or sold. Discounting means lending money upon the negotiable note and deducting interest or a premium in advance. For example, a bank may be willing to pay \$450 for a \$500 promissory note due in one year's time. The amount for which the note can be sold or discounted is the countable value of the note. If it is verified that the note cannot be sold or discounted, it is considered inaccessible.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

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## 5165: Life Insurance and Adjustment of Cash Surrender Value

In both AFDC and SSI related cases verification of the CSV is mandatory when it is countable. The CSV of burial insurance is not countable, and term insurance does not have any CSV. The applicant/recipient may submit the actual policy that includes the Table of Loan and Cash Surrender Value amounts or another statement from the issuing company that gives the necessary information.

The values listed in the table correspond to the number of years the policy has been in effect. The table is usually based on a standard face value of \$1,000. If the face value exceeds the \$1,000, the CSV must be computed accordingly. For example, if the chart shows:

<u>Years held</u>	<u>CSV per \$1,000 Face Value</u>
7	\$110

and the applicant/recipient brings in three policies which are seven years old, the worker computes the CSV:

<u>Face Value</u>	<u>CSV</u>
\$3500	$  \begin{array}{r}  \$110 \\  \times 3.5 \\  \hline  550 \\  330 \\  \hline  \$385.00  \end{array}  $
\$5000	$  \begin{array}{r}  \$110 \\  \times 5 \\  \hline  \$550.00  \end{array}  $
\$6500	$  \begin{array}{r}  \$110 \\  \times 6.5 \\  \hline  550 \\  660 \\  \hline  \$715.00  \end{array}  $

### Example: SSI Related Filing Unit

Mr. and Mrs. J are applying for MA related to SSI for their 5 year old disabled son. The J's have a bank account with a current balance of \$1,523; Mr. J has an insurance policy for \$2,500 on himself; and there is a \$1,200 policy on Mrs. J. The family has only one automobile and no other countable assets. They meet the basic and categorical requirements.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

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STEP	ACTION																
1	<p>Determine the value of each countable asset.</p> <table><tr><td>Bank Account</td><td>-</td><td>\$1,523</td><td></td></tr><tr><td>Mrs. J's insurance policy</td><td>-</td><td>0</td><td>(noncountable - total face value for Mrs. J's policy is less than \$1,500.)</td></tr><tr><td>Automobile</td><td>-</td><td>0</td><td>(noncountable)</td></tr><tr><td>CSV Mr. J's insurance policy.</td><td>-</td><td>\$ 625</td><td>. Policy table indicates per \$1000 CSV = \$250 . Face value is for \$2500 \$250 x 2.5 = \$625</td></tr></table>	Bank Account	-	\$1,523		Mrs. J's insurance policy	-	0	(noncountable - total face value for Mrs. J's policy is less than \$1,500.)	Automobile	-	0	(noncountable)	CSV Mr. J's insurance policy.	-	\$ 625	. Policy table indicates per \$1000 CSV = \$250 . Face value is for \$2500 \$250 x 2.5 = \$625
Bank Account	-	\$1,523															
Mrs. J's insurance policy	-	0	(noncountable - total face value for Mrs. J's policy is less than \$1,500.)														
Automobile	-	0	(noncountable)														
CSV Mr. J's insurance policy.	-	\$ 625	. Policy table indicates per \$1000 CSV = \$250 . Face value is for \$2500 \$250 x 2.5 = \$625														
2	<p>Total the values of all countable assets as determined in Step 1.</p> <table><tr><td>Bank Account</td><td>\$1,523</td></tr><tr><td>CSV Mr. J Policy</td><td>+625</td></tr><tr><td>TOTAL</td><td><u>\$2,148</u></td></tr></table>	Bank Account	\$1,523	CSV Mr. J Policy	+625	TOTAL	<u>\$2,148</u>										
Bank Account	\$1,523																
CSV Mr. J Policy	+625																
TOTAL	<u>\$2,148</u>																
3	<p>Determine the asset limit for the number of persons in the filing unit.</p> <table><tr><td>3 persons</td><td>\$3,100</td></tr></table>	3 persons	\$3,100														
3 persons	\$3,100																
4	<p>Compare the asset limit (Step 3) with the total value of the countable assets (Step 2).</p> <p>The total value of the countable assets (\$2,148) is less than the asset limit (\$3,100). Therefore, the filing unit meets the asset eligibility requirement.</p>																

Adjustment of Cash Surrender Value. When the CSV of life insurance itself, or in combination with other countable assets, exceeds the asset limitation for the filing unit size, a filing unit member is permitted to:

- . reduce the CSV by taking loans against the policy;
- . cancel the policy and withdraw the CSV; or
- . use the CSV to purchase paid up insurance with no CSV.

By taking a loan or withdrawing the CSV the filing unit will receive cash that will be considered an asset. Combined with their other countable assets, the total must be less than the amount of assets allowed for the filing unit size.



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

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Usually the best way to adjust life insurance is to use the excess CSV to purchase paid up insurance with no CSV. The options should be fully explained to the applicant/recipient, and if necessary he should call his insurance agent for advice.

If the applicant/recipient wishes to adjust the value of his life insurance policies, he should contact the agent or agency that issued the policy.

## Example SSI-Related Filing Unit

Mr. and Mrs. B are applying for MA. Mr. B is 72 years old and his wife is 67. They own one automobile, a bank account with a balance of \$1,525, and Mr. B has two life insurance policies with a face value of \$1,500 each. They have no other countable assets and meet the basic and categorical eligibility requirements.

STEP	ACTION												
1	<p>Determine the value of each countable asset.</p> <table><tr><td>Bank Account</td><td>-</td><td>\$1,525</td><td></td></tr><tr><td>Automobile</td><td></td><td>0</td><td>(noncountable)</td></tr><tr><td>CSV Mr. B's insurance policies</td><td>-</td><td>\$2,000</td><td>(Policy Table indicates each policy has CSV of \$1000)</td></tr></table>	Bank Account	-	\$1,525		Automobile		0	(noncountable)	CSV Mr. B's insurance policies	-	\$2,000	(Policy Table indicates each policy has CSV of \$1000)
Bank Account	-	\$1,525											
Automobile		0	(noncountable)										
CSV Mr. B's insurance policies	-	\$2,000	(Policy Table indicates each policy has CSV of \$1000)										
2	<p>Total the values of all countable assets as determined in Step 1.</p> <table><tr><td>Bank Account</td><td>\$1,525</td></tr><tr><td>CSV Mr. B's policies</td><td>2,000</td></tr><tr><td>TOTAL</td><td><u>\$3,525</u></td></tr></table>	Bank Account	\$1,525	CSV Mr. B's policies	2,000	TOTAL	<u>\$3,525</u>						
Bank Account	\$1,525												
CSV Mr. B's policies	2,000												
TOTAL	<u>\$3,525</u>												
3	<p>Determine the asset limit for the number of persons in the filing unit.</p> <table><tr><td>2 persons</td><td>\$3,000</td></tr></table>	2 persons	\$3,000										
2 persons	\$3,000												
4	<p>Compare the asset limit (Step 3) with the total value of the countable assets.</p> <p>The total value of the countable assets (\$3,525) is greater than the asset limit (\$3,000). Therefore, the filing unit is ineligible.</p>												

The options of adjusting and cancelling are explained to Mr. B. If Mr. B cancels one policy, he will receive \$1,000, which will bring the unit's total assets to \$2,525, which is within the allowable asset limitation. The CSV of the second policy with a face value of \$1,500 will no longer be countable because the total face value of all life insurance policies does not exceed \$1,500.

Mr. B decides to cancel one policy and will therefore be eligible. The worker must receive verification from the insurance company.



5166: Discharge and Release of Insurance Assignment for OAA and DA Cases.

Prior to January 1, 1974, the Department took assignments on life insurance policies as an alternative to insurance adjustments on some OAA and DA cases. The Department must release these life insurance assignments without repayment.

The Department will release the life insurance assignment upon the request of the recipient, an interested party acting in the recipient's behalf, or upon inquiry or receipt of a recovery check from the life insurance company.

When a local office receives a check from a life insurance company, the director or his designee shall ascertain whether the payment was made as a result of a life insurance assignment. If so, the director or the designee must return the check to the life insurance company together with an executed Discharge and Release of Life Insurance Assignment, Form A-19. Checks received by the Finance Unit shall be returned to the local office for completion of the above action.

In order to release the assignment, the names of the recipient and the insurance company, and the policy number must be provided by the party contacting the Department. The local office director or the designee must then complete Form A-19 in duplicate. The duplicate will be put into a Life Insurance Assignment Release File to be maintained in the local office. The director or the designee will forward the original Form A-19 to the home office of the insurance company or give the form to the requesting individual, whichever is more appropriate for the situation.



5167: Trust DocumentsIntroduction

This section deals with the treatment of trust documents in determining Medicaid eligibility. Through the use of these guidelines you should be able to determine whether trust income and principal are countable. However, there may be circumstances in which the trust language is obscure and, as a result, you are unable to determine what is countable. In such cases, you should call the Legal Division and seek their guidance and advice.

A trust is a separation of rights to property. A trust is created when the owner of property transfers his or her legal rights to property to a manager for the benefit of himself and/or others. A trust may be set up during the lifetime or, through a will, after the death of the property owner.

The creator of the trust ("grantor", "settlor" or "donor") appoints and authorizes a trustee to manage assets and make distributions on behalf of the person(s) named in the trust ("beneficiaries"). A trustee may be given authority to distribute income or assets ("principal") or both. Trust principal may include any form of property - cash, real estate, stocks, bonds, life insurance.

The trust document sets forth the terms and conditions under which the trustee is required or has discretion to pay income and principal from the trust to the beneficiaries.

To determine whether trust income and principal are countable, you must determine whether the applicant/recipient ("applicant") has (1) a legal right or access to the trust funds or (2) the legal authority to make the funds available to pay for medical care.

I. Revocable and Irrevocable Trusts.

The grantor may declare a trust to be revocable or irrevocable. A trust is presumed to be irrevocable when the trust document does not indicate otherwise.

General Rule - If a trust is declared to be revocable and was created by the applicant, it is always accessible to the applicant. It is accessible because the applicant has the right to "revoke" or dissolve the trust. When a trust is revoked, the trust assets go back to the person who created the trust, in this case the applicant, as grantor. Because all of the trust assets are accessible to the applicant, they are countable in full for purposes of determining the applicant's Medicaid eligibility.

If a trust is "irrevocable" or created by someone other than the applicant, you should continue your analysis using the following information to determine how the trust affects Medicaid eligibility.



II. Medicaid Qualifying Trusts

A trust is a "Medicaid Qualifying Trust" if it has all of the four characteristics listed below. If the applicant submits a Medicaid Qualifying Trust, you should count the trust income and principal to the full extent the trustee has authority (both direct and discretionary) to distribute the income and principal to the applicant.

EXCEPTION: Medicaid Qualifying Trust rules do not apply to any trust established prior to April 6, 1986 for a resident of a state school for the mentally retarded or an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

A) Characteristics of a Medicaid Qualifying Trust

This should be immediately apparent by looking at the document submitted. If the title of the document is "Last will and Testament of...", the trust within is not a Medicaid Qualifying Trust.

Sometimes an applicant sets up a trust naming his spouse as beneficiary, but the trust is not yet funded, and will be funded only upon his death under the terms of his will. Sometimes a trust is partially funded when set up, but receives more funds later under a will.

In these types of trusts, the portion of the trust that is funded under the provisions of a will is not subject to Medicaid Qualifying Trust rules.

B) The applicant must be a beneficiary of the trust

The applicant must be a beneficiary of the trust, but need not be the only beneficiary named. A Medicaid Qualifying Trust may name several beneficiaries.

C) The applicant or his/her spouse must establish the trust

Examples: H. Jones is an applicant for Medicaid. W. Jones is his spouse.

- 1) Whereas, H. Jones of Boston MA, (hereafter called the "Donor"), when reference is made to him in that capacity, is about to transfer and deliver to D. Smith of Boston, MA, certain of his property for the benefit of H. Jones...
- 2) This 4th day of March 1983, D. Smith, of Boston, MA, acknowledges receipt of the property set forth in the annexed schedule "A" from W. Jones, of Boston MA, the Donor, and declares that he will hold the same and any other property which may be transferred to him by the Donor for the benefit of H. Jones and others...



- 3) Trust agreement made April 10, 1981 between H. Jones, of Boston MA (hereafter called the "Grantor") and D. Smith, of Boston MA, (hereafter called the "trustee"), whereby H. Jones is the beneficiary of...

D) The trustee must have discretion to distribute income and/or principal to the applicant

The trustee must have discretion to distribute income and/or principal to the applicant, but this discretion need not be absolute.

For example, the trustee may be directed by the terms of the trust to pay the applicant the sum of \$1,000, and have discretion to make monthly payments of net income to the applicant. The trustee may have no authority, however, to distribute trust principal. In this case, you must count the net income of the trust (because the trustee has the authority to distribute it if he exercises his discretion to do so) and the \$1,000 that the trustee is required to disburse.

Count only the amount of the trust income or principal that the trustee is required to disburse or has discretion to disburse to the applicant for the budget period. If the trust names more than one beneficiary, you must determine from the terms of the trust document itself whether the trustee has authority to distribute all income or principal to the applicant, or only a portion thereof.

Examples:

- 1) "...so much of the net income and principal as the Trustee may determine from time to time shall be paid to or applied for the benefit of the Donor."

. There is no limitation on the Trustee's discretion in this case regarding payments to the Donor, who is the applicant or recipient. The applicant has access to all the money or property in this trust, if all other requirements are met.

- 2) "The Trustee shall use so much, if any, of the net income and principal thereof as the Trustee in his sole discretion deems appropriate for the benefit of the Grantor."

This also gives complete discretion to the Trustee. All the net income and principal are available to the applicant if she or he is the Grantor.

### III. Availability of Trust Income and Principal

If an applicant is the beneficiary of a trust that does not meet the definition of a Medicaid Qualifying Trust described above, then the amount of income and/or principal you should count is determined based on the following questions:

- A) Has the applicant transferred property to the trust within two years of his or her Medicaid application? Were the transferred assets "countable"? Was there a disqualifying transfer? (See 106 CMR 505.120; and Section 5120: Transfer of Assets).
- B) Does the trust give the applicant the right to receive any payments? All income and principal to which the applicant has a legal right should be counted, regardless of whether or not distributions are actually made by the trustee(s). This "right" is usually expressed as a clear directive to the trustee to make payments to the beneficiary, e.g.: "the trustee shall pay all income to the beneficiary and  $1/10$  of the principal assets every three months."
- C) If payment is discretionary, is the applicant receiving any trust income or principal? Income and principal are countable based on actual distributions in a budget period. You do not count the amount that the trustee has the discretion to distribute, unless it is actually distributed.
- D) Does the trust give the applicant the power to terminate the trust or otherwise request funds from the trust? If the applicant has the power to terminate, what are the conditions for termination? Do they apply in this case? Count as available all income and principal to the extent the applicant has the right under the terms of the trust to demand certain payments.
- E) Are there multiple beneficiaries? In a trust which is not a Medicaid Qualifying Trust, unless otherwise provided by the provisions of the trust, each beneficiary is presumed to have an equal share in the trust property.

Examples:

- 1) "The trustee shall pay on a monthly basis all income earned by the trust to the beneficiaries." There are three beneficiaries, one of whom is the applicant, and the trust earns \$600 per month in interest. Result: The applicant has \$200 of countable income per month.
- 2) "The trustee shall pay monthly all income earned by this trust to the beneficiaries according to the following schedule:
- a) 10% to beneficiary A
  - b) 30% to beneficiary B
  - c) 60% to beneficiary C."

The applicant is beneficiary A and the monthly income earned by the trust is \$1000. Result: The applicant has only \$100 of countable income per month (10% of \$1000), even though the applicant is one of three beneficiaries.

If a trust is funded by an asset that is considered "non countable" (e.g., primary residence) for Medicaid eligibility purposes, it should not be considered in determining the value of the available trust property, unless sold or converted into a countable asset.

IV. Verifications

Verification of trust income and assets is required to establish eligibility and at each redetermination. The applicant should provide a periodic accounting of the trust. This can be obtained from the trustee, who has a legal duty to provide an accounting of his or her disbursements from a trust.

If a trust is established by will, verify that the will has been probated.

5171: Exemptions for Burial PurposesA. Burial Space

Includes gravesites, crypts, mausoleums, urns, and other repositories which are customarily and traditionally used for the remains of a family member. In this circumstance, "family member" means an individual's minor and adult children including adopted children and step-children; an individual's siblings, parents, adoptive parents and the spouses of those individuals.

B. Separately Identifiable Amount Not to Exceed \$2500

Includes a revocable burial contract, burial trust, or other burial arrangement or any other separately identifiable fund which is clearly designated as set aside for the individual's burial expenses. If this is a bank account, it cannot be commingled with other funds, and must be verified by a sworn affidavit from the applicant/recipient.

C. Cash Surrender Value of Burial Insurance

Burial Insurance is insurance whose terms specifically provide that the proceeds can be used only to pay the burial expenses of the insured.

Important Note: In Massachusetts this type of policy is usually not sold, but is available from some fraternal organizations. It is also possible that an individual has "burial insurance" purchased in another state.

D. Prepaid Irrevocable Burial Contracts

The applicant/recipient must provide a copy of the contract.

If the value of the contract is less than \$2500, no further verification is necessary, since it would fall under the exemption of a "separately identifiable amount not to exceed \$2500".

If the value of the contract is under \$2500, but \$2500 has already been excluded as in "B" above, or the value of the contract is over \$2500, then the terms of the contract would determine if it is a non-countable asset.

If the express terms of the contract indicate that it is irrevocable, and a claim cannot be made on the principal or interest, no further verification is necessary (see section 5152).

The express contract terms may indicate circumstances under which the contract can be revoked. If it is determined that these circumstances apply at this time, it is a countable asset.



5171 (cont.):

If the terms of the contract are not clear then the applicant/recipient must give the worker written permission to inquire if the funeral home would return the amount on demand.

E. Irrevocable Trusts Designated for Funeral and Burial Expenses.

The applicant/recipient must provide a copy of the trust agreement. If the value of the trust is less than \$2500, no further verification is necessary, since it would fall under the exemption of a "separately identifiable amount not to exceed \$2500".

If the value of the trust is under \$2500, but \$2500 has already been excluded as in "B" and/or "D" above, or the value of the trust is over \$2500, then the terms of the trust would determine if it is a non-countable asset.

If the express terms of a trust indicate that it is irrevocable, and the beneficiary cannot make a claim on the principal or income, no further verification is necessary. (See Section 5152.)

The express terms of the agreement may indicate circumstances under which the trust can be revoked. If these circumstances apply at this time, it is a countable asset.

If the terms of the trust are not clear, then the applicant/recipient must give the worker written permission to inquire if the holder of the trust agreement would pay the amount on demand.

F. Interest or Appreciated Value

On any of the above which are determined non-countable, the interest accrued and/or appreciated value after the date that they are determined non-countable is also non-countable, if left to accumulate and become part of the burial fund.

If any of the excluded resources, including accrued interest or appreciated value once excluded, are used for any purpose other than burial or funeral expenses, the total asset then becomes available and countable.



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5171 (cont.):

5171

## EXAMPLES:

### #1 MA/OAA SSI-Related

Mr. and Mrs. Straight apply for MA/OAA and meet the basic, categorical, and income standards. They own the house in which they live, one automobile, one \$3000 savings account and a second savings account which has \$4500 for their funeral and burial expenses. This is a separate account, and Mr. and Mrs. Straight sign a sworn affidavit that it is to be used for funeral and burial expenses. Mr. Straight also has a term insurance policy for \$2000.

Mr. and Mrs. Straight meet the MA asset standards as their countable assets are \$3000. The worker determines that they are eligible for MA/OAA.

Mr. Straight then has a series of medical problems and spends almost three months in the hospital. The doctors recommend a warmer climate for him.

Mrs. Straight calls the office to inform the FAW that she and Mr. Straight will spend the winter in Florida. They use money from both their savings accounts for this purpose. She says that they have closed their \$3000 account and purchased airline tickets and paid two months rent. Today she took \$500 from their \$4500 account, which had been designated for funeral and burial expenses, as she is going to open a checking account in Florida with \$1000 (\$500 from the other account). Mr. and Mrs. Straight are no longer eligible for MA as they have over \$5000 countable assets.

### #2 MA/AFDC

Mr. and Mrs. Smart apply for MA/AFDC for themselves and their four children. Mr. Smart has been laid off from his job as an engineer. Mrs. Smart is not employed. They meet the basic, categorical, and income standards for MA/AFDC.

5171 (cont.):

The Smarts own the house in which they live, a late model automobile, a \$5000 life insurance policy on Mr. Smart with CSV of \$1850, and a term insurance policy written for both the Smarts so that if either died, the remaining spouse would have the amount of money necessary to pay the mortgage. In addition they have two bank accounts, one for \$2350, and the other for \$12,000 which they claim is intended to allow \$2,000 for each member of the family (\$2500 each is allowed) for funeral and burial expenses. This is a separate account and the Smarts sign a sworn affidavit that it is to be used only for funeral and burial expenses.

The Smarts meet the asset eligibility standard for AFDC (\$3400 for a family of six) as their countable assets are only \$3200 (\$2350 + \$850).

5172: Property Essential to Self-Support

Property essential to self-support is noncountable.

For example, a truck owned by a person who supports himself and his family by long distance hauling is noncountable.

However, if a person owns a truck not essential to his employment, but he claims he receives \$20 every Saturday to haul his neighbor's trash to the dump, it is countable unless it is his primary means of transportation.



5180: Institutionalized Spouse-Treatment of Married Couple's Assets

When an individual whose spouse lives in the community is admitted to a nursing home or medical institution, the appropriate long-term-care unit must assess the couple's combined total countable assets and determine the community spouse's asset allowance provided the following conditions exist:

1. the spouse was institutionalized on or after 9/30/89; and
2. the institutionalized spouse is expected to remain at least 30 days.

If an individual was institutionalized prior to 9/30/89, he or she must spend his or her assets down to \$2,000. The community spouse asset allowance is not available to such individuals and an asset assessment should not be completed.

The community spouse's asset allowance is one-half of the couple's combined total countable assets up to a maximum amount of \$62,580, or a minimum allowance established by the state, whichever is greater. The institutionalized spouse is allowed to keep an additional \$2,000. In Massachusetts the minimum allowance is \$12,516. This means that the community spouse may keep all of the couple's assets if their combined total is \$12,516 or less.

The minimum and maximum asset allowances are subject to a cost-of-living adjustment each year. The assessment must be based on the asset standards that are in effect at the time the assessment is completed. However, Medicaid eligibility is based on the standards that are in effect on the date of application for Medicaid.

Use the following chart as a guideline to help you determine the asset allowance.

If the couple's combined countable assets are:	Then the community spouse's asset allowance is:	The institutionalized spouse can be eligible when the combined assets are reduced to:
\$ 8,000	\$ 8,000	\$ 8,000
\$20,000	\$12,516	\$14,516
\$25,000	\$12,516	\$14,516
\$60,000	\$30,000	\$32,000
\$120,000	\$60,000	\$62,000
\$135,000	\$62,580	\$64,580

Reminder: The Medicaid regulations are used to determine countable and noncountable assets.





5180 (cont.)

Nursing homes will inform couples, upon admission, of their right to have an assessment completed and will advise them of the importance of having the assessment completed right away. Since the assessment is always based on the couple's combined total countable assets as of the first day of a continuous period of institutionalization, it is easier for you and the couple if it is done as soon after the date of institutionalization as possible.

If the couple applies for Medicaid without an assessment and asset allowance, the burden is on the couple to recreate and verify their assets as of the day that institutionalization began.

### Completing the Assessment

When a couple requests an assessment, send them the Medical Assessment Form (MA/NFL-LTCAF). When the form is returned, review it for completeness and be sure the couple has submitted documentation of all countable assets. If documentation is missing, send a letter indicating an assessment will not be done unless all documentation is submitted within 20 days. An assessment should be completed within 30 days of receipt of the assessment form. If the requested documentation is not received, then file the assessment form, copies of all documentation submitted, and a copy of your letter.

When you have the necessary information, determine the community spouse's asset allowance, and send each spouse a copy of the Notice of Available Assets (MA/NFL-N2A), with a worksheet explaining how you determined it.

Either spouse can appeal the amount of assets that were counted at assessment or the computation of the community spouse's asset allowance, but only after an application for Medicaid has been made and a disposition notice sent. If the income generated from the asset allowance does not provide enough income to meet the monthly spousal needs allowance, the Division of Hearings may increase the asset allowance by an amount that will provide the monthly allowance, or an amount allowed by the fair hearing officer.

#### Example 1:

Mr. A. enters a nursing home on 10/14/89 and he and Mrs. A. request an immediate assessment. They verify their assets and you determine that their combined total countable assets are \$46,000. Mrs. A's asset allowance is \$23,000. Mr. A. will have met the asset standard for Medicaid when their combined assets are reduced to \$25,000 (\$23,000 + \$2,000).

#### Example 2:

Mr. B. enters the hospital on 10/14/89, and remains there until he enters a nursing home on 1/15/90. In August 1990, when Mr. B. applies for Medicaid, the couple's combined assets are \$19,800. The B's recreate and verify the amount they held in assets on 10/14/89. Their assets then were \$46,000. Since Mrs. B's asset allowance is \$23,000, she may keep the \$19,800 which is all of their current combined total assets.

5180: (cont.)

When a community spouse has been awarded assets by a court order, the amount allowed for the community spouse's asset allowance is the higher of the two amounts, the court order or the asset allowance calculation by the Department.

## Example 3:

Mr. C. enters a nursing home in November 1989, and requests an assessment. Mr. and Mrs. C. are separated and she has received a court order for separate support. She was awarded \$65,000 in assets by the court order, and retains all of it. Mr. C's total countable assets are \$26,000. Their combined assets are \$91,000. Since the court order is greater than Mrs. C's asset allowance (\$45,500) as calculated by the Department, her asset allowance is \$65,000. Mr. C. will meet the asset standard for Medicaid when their combined assets are \$67,000.

## Example 4:

Mr. D. entered a nursing home in July 1989, and applies for Medicaid in November 1989. He has \$1200 in assets, and Mrs. D. has \$110,000 held solely in her name. Since he began his continuous period of eligibility before 9/30/89, the regulations and procedures for financial responsibility in effect before 9/30/89 apply. Therefore, Mrs. D. is not responsible for him, and her assets are not counted in determining his eligibility. Mr. D. is eligible for Medicaid as of the date his assets were spent down to \$2,000.





Eligibility Determination

When the institutionalized individual subsequently applies for Medicaid, deduct the community spouse's asset allowance and the institutionalized spouse's \$2,000 asset allowance from the couple's combined total assets. If the result is zero or a deficit, the institutionalized spouse meets the Medicaid asset standard.

Reminder: All the Department's asset eligibility rules, such as transfer and accessibility, apply when you determine eligibility.

Example:

Mr. A. from example 1 applies for Medicaid in March 1990. Mrs. A's asset allowance is \$23,000. The A's total assets as of the date of application are \$25,000. They have spent \$21,000 on his nursing home bills and on a new porch for their home. The A's meet the asset eligibility standard and Mr. A. is determined eligible for Medicaid.

Appeals

Either spouse can appeal the amount of assets that were counted at assessment or the computation of the community spouse's asset allowance but only after an application for MA has been made and a disposition notice sent. If the income generated from the asset allowance does not provide enough income to meet the monthly spousal needs allowance (Section 6222), the Division of Hearings may increase the asset allowance by an amount that will provide the monthly allowance, or an amount allowed by the fair hearing.

Post Eligibility

After the institutionalized spouse has been determined eligible for Medicaid, all of the couple's assets that are considered part of the community spouse's asset allowance must be made available to the community spouse. The assets that are in the name of the institutionalized spouse must be transferred to the community spouse, and the institutionalized spouse's name must be removed from joint assets. This transfer must be made as soon as the couple is able to do it, but it must be completed within 90 days. Any assets remaining in the institutionalized spouse's name after the 90-day grace period will be counted in determining his or her continued eligibility.

Exception: If the institutionalized spouse is not competent and there is no guardian, the transfer can be delayed until after a guardian is appointed.



5180 (cont.)

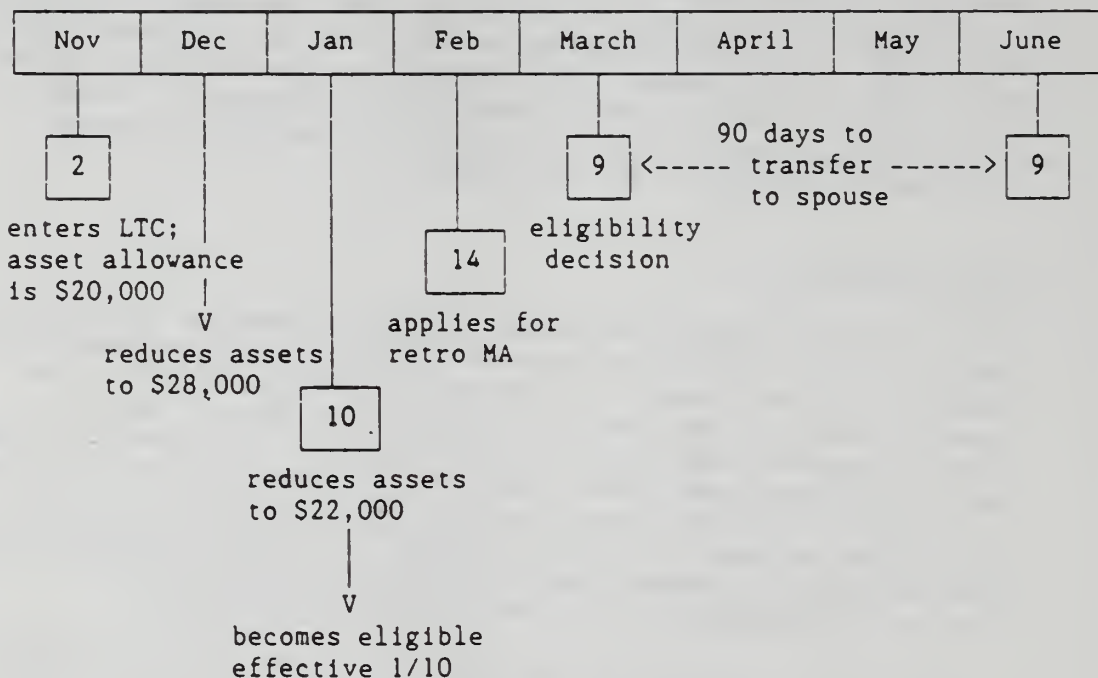
Retroactive Eligibility

If an institutionalized individual applied for retroactive coverage, eligibility during the retroactive period can be established, allowing the community spouse's asset allowance and the \$2,000 institutionalized spouse asset allowance as deductions from total assets.

Example:

On November 2, Mr. S. enters a nursing home. On February 14 he applies for MA retroactive to November 2. The assessment is completed, showing Mr. and Mrs. S had total combined assets of \$40,000 on November 2. The asset allowance for Mrs. S. who lives in the community is \$20,000. Since Mr. S. can keep \$2,000, they must reduce their assets to \$22,000 before he can become eligible for Medicaid.

He is ineligible in November because they are over their asset limit by \$18,000 in November. In December, they have reduced the assets to \$28,000 and on January 10 their combined total assets are \$22,000. He becomes eligible for MA, effective January 10 and must transfer all assets over \$2,000 that are in his name to his wife within 90 days of the eligibility decision.





5210: Earned Income

Earned income includes income from employment (wages, salary or income in kind), income from self-employment, income from roomers and boarders, and under certain circumstances, income from real estate.

5211: Income from EmploymentA. Definition

Wages are remuneration from employment paid by an employer either in cash or in-kind. They may take the form of an hourly or daily stipend (sometimes called hourly wages); they may be paid as fixed compensation during the period of employment regardless of the amount of time devoted (usually called salary); or they may be based upon the number of items produced or units of work performed (piece work).

Regardless of the basis for the payment or the regularity, other countable earnings to be treated as wages include:

bonus or other incentive payments added to the basic wage rate;

tips, which are gratuities received for services rendered while performing a job for wages or salary whether paid directly by persons other than the employer or paid over to the employee by the employer (e.g., a restaurant patron may charge the tip using his credit card).

income-in-kind other than cash provided by the employer to the applicant/recipient. It may consist of but is not limited to free services, rent, utilities, clothing or food. The value of income-in-kind shall be the fair market value of goods or services received, except as specified in 106 CMR 505.230.

Example - Income-In-Kind

Mrs. M, a single woman with 2 children, works as a baby-sitter and cook on a small estate. There is a guest cottage on the grounds, which is now their home. She does not pay rent, and the heat and utilities are provided by her employer. They do not eat their meals in her employer's house. She receives a weekly salary of \$100.

Mrs. M's monthly income includes her monthly salary and the income-in-kind standard allowances for heated shelter and utilities. Her gross monthly income is:

Weekly Salary x 4.333	\$433.30
Allowance for Heated Shelter	126.30
Allowance for Utilities	+ 18.60
= Countable monthly gross income -	\$578.20

This is the amount the worker will use in determining net monthly income and eligibility for the MA family.

B. Verification of Income from Employment

See 106 CMR 505.210.

5212: Income from Self-EmploymentA. Definition

Self-employment income is net earnings after allowable business expenses derived from engaging in a trade or business, either as a sole proprietor, or as a partner with one or more other partners.

Mere possession of assets (for example, buildings or securities) which yield income does not constitute self-employment. While there are borderline cases, self-employment can generally be distinguished by asking the following questions:

1. Does the person in question report only to himself?
2. Can the person in question decide his own hours and days of work?
3. Does the person in question have to report earnings (for other than tax purposes) to anyone else?
4. If there are employees in the business, do they finally answer to anyone other than the person in question?
5. Does anyone set the salary or wages of the person in question, or does he set it himself?
6. Does the person in question own the business outright? If there are co-owners, what is the arrangement with them? (Situations in which there are a number of investors in a business, only one of whom works, are not uncommon.)

If the worker still has doubts after exploring these questions, the case should be discussed with his supervisor. If he cannot resolve the matter, the director or designee may request a determination from Central Office.

B. Determination and Verification of Self-Employment Income

Earnings from self-employment are total income less actual business expenses. Business expenses include all costs necessary to maintain the business; they do not include personal expenses such as lunches or transportation to and from work. Before deducting work-related expenses, you must determine the amount of total receipts and subtract the amount of business expenses.

Total receipts and actual business expenses must be verified by examining business or tax (state, federal, or local) records for the 12 most recent months. The income less business expenses for the last 12 months, divided by 12, is to be used as the projected monthly income.

Business expenses may include but are not limited to the following items that the applicant/recipient can document:

- . rent for the premises in which the business is conducted, if rented;
- . mortgage payments for the premises, if owned;
- . property taxes less abatements and including betterments, for the premises, if owned;
- . insurance for the business;
- . utilities (heat, air conditioning, lighting, water, electricity, garbage collection);
- . special utilities needed to conduct the business (high voltage lines, special gases);
- . cost of licenses needed to conduct business;
- . cost of goods sold;
- . advertising costs;
- . costs of printing business forms, signs, and cards;
- . telephone costs;
- . wages, salaries, and commissions paid to employees;
- . depreciation on owned equipment properties;
- . costs of improving owned or rented properties;
- . costs of generating new business;
- . costs of vehicles used in the conduct of the business and expenses for same;

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- . costs of benefits to employees, such as the employer's share of Social Security taxes, health and life insurance, IRA plans, and wages paid for sick leave, vacations, and holidays; and
- . other taxes levied directly on the business, not the owner.

NOTE: If the business is housed in the applicant's/recipient's home, the expenses which apply must be prorated.

## 5213: Income from Roomers and Boarders

### A. Definition

Room and Board income is received in payment for room and/or board furnished to anyone other than a member of the filing unit or a child of the grantee relative.

### B. Determination and Verification of Income from Roomers and Boarders

It is mandatory to verify income from roomers and boarders by one of the documents found in 106 CMR 505.210.

Unless the applicant/recipient contends that his or her business expenses are higher, the following flat deductions will be allowed for business expenses:

25% of the income received from roomers; and

75% of the income from roomers who also receive board.

If the applicant/recipient contends that his expenses are higher than the percentages given above, business expenses must be determined and verified from receipts documenting actual expenses. The expenses can include expenses listed in 5225: Income from Real Estate (Unearned) and can also include:

food and cooking;

food storage; and

linens and laundry.

If the costs of the personal expenses of the members of the applicant's/recipient's family are inextricably combined with the costs of food, food storage, and linens and laundry for roomers and boarders, allocate costs as follows:

Cost of food, linens, laundry  $\times \frac{(\text{Total Roomers Receiving Service})}{(\text{Total Persons Receiving Service})}$

= allowable business expense



5214: Income from Real Estate (Earned)A. Definition

Rental income may be earned or unearned depending on the circumstances. The income is considered earned if it is received in the course of a trade or business as a real estate dealer.

106 CMR 505.210 defines a real estate dealer as "one engaged in the business of selling real estate to customers for a profit. One who holds real estate for investment or speculation, and receives rental income, is not a real estate dealer."

This situation would occur very seldom since a person who is in the business of buying or selling real estate for a profit will probably not meet the MA financial eligibility standards.

The amount of earned rental income to be counted is the total rental income less business expenses. In AFDC-related cases there are no work-related expense deductions applied to rental income. In SSI-related cases the standard earned income deduction is allowed. See Section 6127 for examples.

B. Verification of Income from Real Estate

When it is considered earned income, rental income must be verified by tax records (copy of most recent income tax return), leases, or rental agency documents.

The allowable business expenses for income from real estate that is earned can be found in 106 CMR 505.210(C).



5220: Unearned Income

Unearned income includes income from benefit payments (for example, pensions and Social Security), contributions and support payments, income from investments, income in-kind, and usually income from real estate.

5221: Income From Benefit Payments

See 106 CMR 505.220 (A) (1) for examples of benefit payments.

Verification of Income from Benefit Payments

It is mandatory to verify income from benefit payments, and the applicant/recipient must provide one of the documents listed in 106 CMR 505.220(A)(2).

In the case of copies of checks, the worker must be sure that he has accurate information as to how often the checks are received i.e., monthly, bi-monthly, weekly.

5222: Contributions and Support PaymentsA. Definition

Alimony, Child Support and regular contributions from friends and relatives except as described in 106 CMR 505.230 are considered unearned income in all MA cases.

An amount up to fifty dollars (\$50) of a current monthly support payment received by an AFDC-related assistance unit for a child(ren) and/or spouse is disregarded.

One-third of child support payments paid by an absent parent on behalf of a disabled child in an SSI-related case is noncountable income.

B. Verification of Contribution and Support Payments

See 106 CMR 505.220 (B) (2).

5223: Income From InvestmentsA. Definition

Income from investments includes but is not limited to:

- . dividends,
- . interest,
- . royalties.

B. Verification of Investment Income

See 106 CMR 505.220 (C) (2).

5224: Income-In-Kind (Unearned)A. Definition

Income-in-kind is income in any form other than money provided to the applicant/recipient. It may consist of free services, rent or mortgage payments, utilities, clothing, or food, but it is not necessarily limited to these. See Section 5211 for an example of income-in-kind when treated as earned income.

B. Verification of Income-In-Kind

See 106 CMR 505.220 (D) (2).

5225: Income from Real Estate (Unearned)A. Definition

Rental income is considered unearned income unless it is received in the course of a trade or business, as a real estate dealer, as defined in 106 CMR 505.210. (See 5214: Income from Real Estate (Earned))

The countable amount of rental income is total rental income received less business expenses.

B. Business Expenses

The business expenses which may be deducted from rental income in total are:

- . Actual verified cost of maintenance and repairs of the property except costs for purely cosmetic purposes; and
- . Fees paid to a rental agent, if verified.

The following business expenses must be prorated per unit if the applicant/recipient lives in the building:

1. Carrying charges, consisting of principal and interest payments on the mortgage, taxes less abatements, betterment taxes, water service, garbage and trash collection, and owners' property insurance premiums; and
2. Fuel and utilities if they are provided through a single heating unit or meter. (If each unit has a separate meter and the landlord pays the entire bill, only the amount paid for the rental units may be deducted.)

C. Verification of Rental Income

See 106 CMR 505.220 (E) (2).

D. Verification of Business Expenses

It is mandatory for the applicant/recipient to verify for the most recent twelve months all claimed business expenses by providing all of the following that are appropriate.

See 106 CMR 505.220 (E) (2) for a list of the preferred sources of verification.

All costs should be documented for one year, then divided by 12 to obtain an average monthly cost. This is then deducted from the average monthly rent received to obtain the countable rental income.

When the applicant/recipient lives in one apartment or section of a multi-family dwelling, business expenses are determined in the following manner.

Example Mr. and Mrs. A, ages 68 and 66, are applying for MA-OAA. They meet the basic and categorical eligibility standards. They own a three family house, and rent the second and third floor apartments. Neither Mr. or Mrs. A is a real estate dealer.

Actual verified amount of maintenance and repairs on the property for the most recent twelve months:

3rd floor apartment	
4 plumbing bills	\$ 420 ÷ 12 = \$35/mo.
1st floor apartment	
electrician's bill	\$ 336 ÷ 12 = \$28/mo.
New roof	<u>\$3,600 ÷ 12 = \$300/mo.</u>

Total Maintenance and Repair Bills = \$363/mo.

Actual verified carrying charges:

Mortgage	\$ 0/mo.
Taxes	\$222/mo.
Water	\$ 25/mo.
Insurance	\$ 65/mo.
Total carrying charges	<u>\$312/mo.</u>

Only that portion of these expenses which applies to the rental unit can be deducted:

2/3 of \$312 = \$208 per mo. - total deductible carrying charges

Business expenses to be deducted from total monthly rental income are therefore \$571 per month.

Total maintenance and repair bills	\$363
Plus prorated carrying charges	<u>\$208</u>
Total business expenses allowed	\$571/mo.

If the amount of rent received exceeds business expenses, the difference is the amount considered as rental income.

If the business expenses exceed the amount of rent, there is no rental income.

## 5226: Lump Sum Payments

### A. Definition

See 106 CMR 505.220 (F) (1).

### B. Verification of Lump Sum Payments

It is mandatory to verify the amount of the payment and the date of receipt. The applicant/recipient must provide one of the documents found in 106 CMR 505.220 (F) (2).

### C. Treatment as Income

All lump sum payments except as listed in 106 CMR 505.220 (F) (1) must be considered as income to the applicant/recipient in the calendar month in which they are actually received. The amount of such a payment would then be computed as part of the six-month spend-down, but only for one month.

**Example** If the regular countable income is \$501 per month, and in one month the applicant/recipient receives \$1200 retro-active Social Security, then in that month the countable income is \$1701.

The spenddown would be determined as follows:

January-May \$501 Income	June \$1701
-20 SSI-disregard	-20
<u>481</u> July & August	<u>1681</u>
-451 MA Standard	-451
<u>30</u>	<u>1230</u> Month of lump sum
x 5	+150 Other 5 months
<u>150</u>	<u>1380</u> Total 6 month SD

D. Treatment as Asset

## Retroactive SSI and RSDI Benefit Payments

On the first day of the seventh calendar month after the month of receipt the amount of a retroactive RSDI and/or SSI benefit still retained becomes a countable asset.

Example Mr. and Mrs. H apply for MA/OAA in September. Their six month spenddown is \$612. On October 5th they receive a retroactive RSDI check for \$750 and notify the worker. Their monthly RSDI benefit has not increased, but the \$750 additional income for October is added to their total six-month income, thereby increasing the six-month spenddown to \$1362.

In February, Mr and Mrs. H reapply for MA and have two bank accounts with balances of \$2800 and \$400. They would have excess assets of \$200 except that the \$400 account represents the remainder of the retroactive RSDI benefit. The worker should inform Mr. and Mrs. H that as of May 1 any part of this \$400 still left becomes a countable asset and must be included in determining eligibility.



5300: The Budget Period

Since the MA Income Standards are expressed in monthly amounts, income must be converted to a monthly figure, in order to compare it to the standard. Monthly excess income amounts must be multiplied by six to determine the spend-down liability (See 6520).

5310: Adjustments to the Budget Period

- A. Self-Employment - The 12 months' income preceding the date of application or redetermination is used to compute the average monthly income.
- B. Seasonal Employment - Income is based on actual earnings in the most recent earning season.
- C. Irregular - Actual Income for three months is used to compute average monthly salary.
- D. Reduced or Terminated Employment - Income is based on the anticipated termination date as verified in writing by the employer.

Changes in applicant's/recipient's employment which might result in using the most recent information to predict his future, even if it is less than four weeks, would be:

- A. changes from part-time to full-time, or full-time to part-time employment;
- B. changes in jobs;
- C. promotions or demotions;
- D. raises;
- E. stopping or starting work;
- F. increases or decreases in hourly wages.

The amount of income actually received in the retroactive month(s) is the amount of income used for those months in the determination of eligibility. However, the prospective part of the six-month period is done in the usual way, and added to the retroactive period amount.

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## Example 1: Self Employment

On 1/11/86, Mrs. K made application for assistance for herself and her four children. Mrs. K is a self-employed seamstress. Mrs. K included with the application form business ledger sheets and an income tax statement for 1985. Mrs. K reported total gross income of \$8,763.78 and total business expenses of \$2,987.43 in 1985.

### Subtract Total Business Expenses from Total Gross Income.

Total Gross Income	\$8,763.78
Total Business Expenses	<u>-2,987.43</u>
Annual Income	\$5,776.35

### Convert to Monthly Amount.

Monthly Income	\$481.36
Conversion Factor	12 $\overline{) 5,776.35}$ Gross Annual Income

## Example 2: Seasonal Employment

Mrs. P made an application on 8/3/85 for Medical Assistance for herself and her two children. Mrs. P is a migrant worker. She arrived in Massachusetts on 6/2/85 and started working on 6/5/85. Mrs. P's employment will terminate 9/30/85 at which time she and her children will return to Florida. She is paid weekly. Her last four pay checks were in the amounts of \$122.00, \$126.50, \$131.00, and \$118.75.

The worker should average the four week's salary and convert to a monthly amount. The monthly amount is then used to determine eligibility.

The worker should set up a tickler file so that this case will close on 9/20/85, and no MA-ID card will be issued for October, 1985.

## Example 3: Irregular Employment

Mrs. S has made application for Medical Assistance for herself and her two children. She is working as a fill-in waitress.

The worker should request employer verification of Mrs. S's most recent three months' salary including tips. The worker totals the three months' income and divides by three for the monthly amount. The monthly amount is then used to determine eligibility.

Example 4: Reduced Employment

Ms. P has made application for Medical Assistance. Ms. P is two months pregnant and, under her doctor's instructions, she must eventually reduce her work hours. Ms. P. intends to work full-time for the next three months and work twenty hours a week for the term of her pregnancy. Ms. P is paid weekly at an hourly rate of \$3.50. Medical verification of the required work schedule is provided.

The worker should calculate an average monthly amount projecting three months of full-time earnings and three months of part-time earnings.

<u>Full-Time</u>	<u>Part-Time</u>
Gross Monthly	Gross Monthly
-Disregards	-Disregards
<u>Net Income</u>	<u>Net Income</u>
-MA Standard of Assistance	-MA Standard of Assistance
<u>Excess Income</u>	<u>Excess Income</u>
x3	x3
<u>y</u>	<u>z</u>

y plus z = excess income for  
6-month prospective period

Example 5: Terminated Employment

Ms. G who is five months pregnant, has made application for Medical Assistance on 7/11/85. She works as a secretary and is paid \$200 weekly. Ms. G plans to take a medical leave of absence from her job on 10/1/85 and return to work on 12/15/85. Ms. G will receive no compensation from her employer between 10/1/85 and 12/15/85.

The worker should convert current weekly income to a monthly amount. In this case three months income would be received in the six month eligibility period; the worker should calculate eligibility accordingly.

5320: Conversions to Monthly Amounts

Unless it is paid monthly, all income must be converted to a monthly amount before being used in eligibility calculations. This is explained in 106 CMR 505.320.

Example 1 Biweekly Income

Mrs. L received irregular gross wages for the three biweekly payroll periods prior to her date of application. The checks were in the amounts of \$197.80, \$164.30, and \$189.85.

A. Determining Average Biweekly Amount

\$197.80	1st biweekly period
164.30	2nd biweekly period
2)362.10	
\$181.05	average biweekly amount

B. Convert to Monthly Amount

\$181.05	Average Biweekly Amount
2.167	Conversion Factor
\$392.34	Average Gross Monthly Income

Example 2 Semimonthly Income

Mrs. W receives regular gross wages of \$205.63 semimonthly.

A. Convert to Monthly Amount

\$205.63	Gross Semimonthly Income
x2	Conversion Factor
\$411.26	Gross Monthly Income

Example 3 Annual Income

Mrs. E is a teacher. She is employed from September through June, and is paid \$550.00 semimonthly for those ten months. She receives no money from the school system in July and August, and is not employed elsewhere for those two months.

A. Convert to Annual Income

\$550.00	Income received semimonthly
x2	Conversion Factor
\$1100.00	
x10	
\$11,000.00	Gross Annual Income

B. Convert to Monthly Amount

916.67	Gross Monthly Income
12)11,000.00	Gross Annual Income



5400: FINANCIAL RESPONSIBILITY

The general rule that applies to financial responsibility in Medical Assistance is that spouse is responsible for spouse, and parent is responsible for children under 18.

5410: Natural and Adoptive Parents

A parent is financially responsible for his or her children under 18 unless the child meets one of the following conditions.

- A. The child is an emancipated minor, that is, an individual under the age of 18 who:
- is married, divorced, or separated;
  - has served in the armed forces; or
  - has been emancipated by the courts.
- B. The child under the age of 18 is in a long-term-care facility. The parents are financially responsible for the child for the entire calendar month in which the separation takes place but are not responsible thereafter.

EXAMPLE - Dependent Child in Pediatric Nursing Home

On June 27th, Mr. Clark applies for Medical Assistance for his 14-year-old daughter who will be admitted to a pediatric nursing home on July 15th. Mr. Clark works full-time for a gross monthly salary of \$1,500. He has \$19.60 per month deducted from his salary for his health insurance premium and his employer pays the rest. Mr. Clark also supports his wife and two other children. The family's assets are less than the asset limitation.

Determine the Patient-Paid Amount for the month of separation.

\$1500.00	Mr. Clark's Gross Monthly Income
-	AFDC-Related Work-Related Expenses
- 19.60	Health Insurance Premium
=	Net MA Income
-	Community Income Standard for five
=	Patient-Paid Amount for July

NOTE: If Mr. Clark wishes to apply for the rest of the family, the other two children would be categorically eligible for MA-Under 21, and financially eligible for July based on the same calculation.

Determine the Patient-Paid Amount for the month after the month of separation.

The multiple-handicapped daughter has no income of her own. The Patient-Paid Amount for August is zero. The Department will provide a PNA Payment.



NOTE: If Mr. Clark wishes to apply for or maintain the eligibility of the other two children, as of August 1, a six month spenddown must be calculated.

$$\begin{array}{r}
 \text{Net MA Income - from above} \\
 - \text{Community Income Standard for four} \\
 = \text{One Month Excess Income} \\
 \text{-----} \\
 \text{-----} \times 6 \text{-----} \\
 = \text{Six-Month Spenddown Liability}
 \end{array}$$

If the family chooses voluntarily to contribute toward the cost of care, redetermine the Patient-Paid Amount for the month after the month of separation.

$$\begin{array}{r}
 \text{Monthly Voluntary Contribution} \\
 + \text{Patient's Income} \\
 = \text{Net MA Income} \\
 - \text{Personal Needs Allowance} \\
 = \text{Patient-Paid Amount for August}
 \end{array}$$

NOTE: This voluntary contribution would be used in computing eligibility for MA-21 for the other two children. If it equaled or exceeded the excess monthly income, the other two children would be eligible. If it was less than the excess monthly income, it could be used to meet the spenddown.

- C. The child under the age of 18 is SSI-related, is in an acute hospital, and is not expected to return to the parental home by the end of the month following the month of separation. For newborns who have never resided with their parents, the date of birth is the date of separation. The parents are not financially responsible for the child from the date of separation.

#### EXAMPLE - SSI-Related Child in an Acute Hospital

On April 17th, Mrs. Rivers applies for Medical Assistance for her only child, Linda, 10 years old who has sustained a severe head injury and has been hospitalized since April 5th. Mr. and Mrs. Rivers own two automobiles, have an IRA, and \$6000 in the bank. Their income is \$2200 per month. Linda has no income, but has a bank account with a balance of \$850.

Mrs. Rivers submitted medical verification that her daughter will not be discharged from the hospital by the end of May. The worker submits this case to DDU and Linda is determined to be disabled.

Since Linda will not be returning to her parental home by the end of May, only her income and assets are counted in determining financial eligibility. She is eligible without a spenddown as of April 5th.

NOTE: You should inform Mr. & Mrs. Rivers about their options. If Linda will be hospitalized, institutionalized or both, they should look into potential eligibility for SSI.

If it appears that Linda will be coming home soon or if Linda's future is unclear, you should inform the parents of their financial responsibility for Linda at home, and give them all available information on the Kaileigh Mulligan program.

5420: Grantee-Relatives Other Than Parents5421: Financial Responsibility

A grantee relative who is not the child's parent has no financial responsibility for the child.

EXAMPLE: - MA-21 - Grantee-Relative Other than Parent

Mr. and Mrs. S. are applying for MA-21 for her 8-year-old niece, Katherine. Katherine's parents are deceased and she receives \$250 per month from SSA. She meets the test of eligibility for assets. Mr. and Mrs. S. are both employed, his salary is \$36,000 per year, and hers is \$27,500. They do not have children.

Determine the income to be used in computing financial eligibility. Katherine's income is \$250 per month.

Determine financial eligibility.

\$250.00 Gross Monthly Income  
 - MA Community Income Standard for One  
 -----  
 = Deficit = Financial Eligibility for MA-21

5422: Inclusion in the Assistance Unit

The grantee relative and his or her spouse may choose to be in the assistance unit. Their assets and income are counted as they are now financially responsible.

EXAMPLE: - MA-AFDC-Grantee Relative Other than Parent Included.

Mr. and Mrs. D. have his three nephews, Hugh, 10, Louis, 8, and Dewey, 6 living with them. The boys' father deserted them seven years ago, and their mother went to Las Vegas in 1979 to look for employment. She sends money to the boys for birth-days and Christmas, but does not support them. Mr. D. has been employed until last month earning approximately \$25,000 per year, and supported his nephews. Mrs. D. quit her job to stay at home with the boys. Mr. D. began receiving U.C.C. two weeks ago. Three days ago, Mrs. D. had an appendicitis attack, and was operated on immediately. Mr. D. no longer has health insurance and is applying for MA in order to pay his wife's medical bills. He owns his home, an automobile, and has a bank account balance of \$2565.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

5422-2

Determine whose income is to be used to compute eligibility. The boys' income and the D.'s income are used, as the D.'s want to be included in the assistance unit.

Compute eligibility. The boys have no income.

\$676.00	Mr. D.'s Monthly UCC
-531.00	MA Community Income Standard for 5
<u>145.00</u>	Monthly Excess Income
x6	
<u>\$870.00</u>	Six-Month Spenddown Liability

After the D.'s and their nephews have incurred \$870.00 in medical bills, their remaining bills for the six months will be paid by MA.

At the end of this period, if the D.'s no longer need MA, they can apply for MA-21 for their nephews, who will be immediately eligible.



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

5430  
5431  
5432

## 5430: Recipients of Supplemental Security Income (SSI)

### 5431: Financial Responsibility

Recipients of SSI are not financially responsible for any applicant/recipient of MA. It makes no difference what the relationship is.

#### EXAMPLE: - Recipient of SSI - Parent

Mrs. A. is applying for MA-21 for her three children. Mrs. A. receives \$387.49 per month SSI-D. She has a bank account with a balance of \$1275.00. The children receive \$100.00 per week child support from their father. They have no assets.

Determine the income to be used to compute eligibility. The children's income is \$433.33 per month.

\$433.33 Gross Monthly Income  
- MA Community Income Standard for 3  
= Monthly deficit - Financial Eligibility for MA-21

### 5432: Exclusion in the Assistance Unit

Recipients of SSI are never included in the assistance or filing unit applying separately for Medical Assistance.

If the only child in the home is receiving SSI, his parent(s) or grantee-relative and his spouse may establish categorical eligibility for MA-AFDC (on the basis of the SSI child). He is not a member of the filing or assistance unit, and his income and assets are not considered.

#### EXAMPLE: - MA-AFDC - Only Child Receiving SSI

Mr. and Mrs. C. are applying for MA-AFDC. They have one 12-year old son who is receiving SSI-D of \$269.95 per month. Mr. C. has recently been laid off his job and is receiving \$96.00 per week Unemployment Compensation. They meet the asset eligibility standard.

Determine the income to be used in computing eligibility. Mr. and Mrs. C. have income of \$416.00 per month.

Compute their financial eligibility for MA-AFDC.

416.00 Gross Monthly Income  
- MA Community Income Standard for 2  
= Deficit - Financial Eligibility for MA-AFDC



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

## 5440: Stepparents

## 5441: Financial Responsibility

When a child's parent remarries, the stepparent has no financial responsibility for the child. The spouses are mutually responsible for each other.

There is a formula applied to the stepparent's income (Chapter VI, Section 6330), which determines the amount of the financial responsibility. If the natural parent applies for MA-AFDC with his children, this amount is part of the unit's countable income.

If the parent applies for MA-21 for the children only, the stepparent's income is not considered.

The natural parent's income is counted in total in both cases.

## 5442: Inclusion in the Assistance Unit

The stepparent can be included in the assistance unit if he chooses and meets the basic and categorical eligibility requirements. When he becomes part of the assistance unit, his assets and income are counted.

Mr. and Mrs. J. are applying for MA-AFDC for themselves, her three children, and their two children. Mrs. J's three children have been receiving MA-21. They have no income of their own, as their father's whereabouts is unknown, and Mrs. J. is not employed. They have no assets.

Mr. J. was laid off last month, is receiving \$140 per week U.C.C., and one of his children has become ill. Mr. and Mrs. J. have one automobile and \$3265 in the bank.

Determine the income and assets to be considered. Mr. and Mrs. J's income and assets, their children's income and assets are all considered.

Determine the asset limit for a family of seven. It is \$3500. The J's meet the assets eligibility. Determine income eligibility.

606.67 - Mr. J's U.C.C.  
-667.00 - MA Community Standard for 7  
= Deficit

The J's are eligible for MA-AFDC. Mrs. J's children are eligible for AFDC but the J's do not want to apply for this.

5450: Spouses

The general rule is that spouses are only responsible for each other for the days they live together. If there are alimony payments, payments from a spouse's pension plan, income from property which is jointly owned (e.g., the applicant/recipient resides in a multi-family dwelling, owned jointly with his or her spouse), or any other such payments, they are considered as income to the applicant/recipient. When the spouses are separated, this income is counted only if it is actually received.

The assets of spouses living apart because one of them entered a long-term-care facility or SNF before 9/30/89 and remains in the long-term-care facility or SNF, or entered a hospital before 9/30/89 and remains hospitalized on administrative days, are mutually available only until the end of the month of separation. Income is attributed in accordance with Sections 6220-6224.

5451-5453: Reserved5454: Waiver of Financial Responsibility of Spouse for Spouse

The Department has received approval of a waiver from the federal government to disregard the financial responsibility of spouse for spouse in certain circumstances as described below.

If an applicant/recipient residing with his spouse is 60 years or older, has been certified by the Long Term Care Connection (LTCC) to be in need of Level II or Level III care (see 7440), and through the Department of Elderly Affairs (DEA) is receiving one or more of the following services without which he would have to be institutionalized, only the individual's own income and assets are used to determine his financial eligibility.

The following services are covered under this waiver:

Case Management Services  
Homemaker Service  
Chore Service  
Social Day Care  
Respite Care Service

NOTE: Bills incurred for these services may be used toward the individual's spenddown.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

5454 (con't)

Verification of the LTC certification and the receipt of the appropriate service(s) will be by the Long Term Care Connection Level of Care Authorization Form (F5454).

If an applicant/recipient receives one of these services but the worker does not have the Authorization Form, the worker should call the local LTCC (7441).

If a resident of a long-term-care facility is being considered for a return to his home with at least one of the above services, the LTCU should retain the case until a decision is made. If the patient is to return home, the LTCU worker should determine eligibility under the terms of this waiver, and then transfer the case to the appropriate Area Office/Branch Office.

## Example:

Mr. and Mrs. S, both age 69, apply for MA. Mr. S receives a monthly pension of \$750. Mrs. S receives a Social Security check of \$515. Each has a \$1500 life insurance policy and they have a joint bank account of \$1250.

\$ 750	Mr. S's pension
515	Mrs. S's Social Security
<u>\$1265</u>	Total monthly income
- 20	Unearned Income Deduction
<u>\$1245</u>	
- 483	MA Income Standard for 2
<u>\$ 762</u>	Excess monthly income
x 6	
<u>\$ 4572</u>	Six-month spenddown

Three months later, Mrs. S has a stroke. They have not met their six-month spenddown. The hospital submits a new MA application and the worker receives the Authorization Form verifying that Mrs. S is in need of Level II care and will receive the appropriate home care services to allow her to return home. If the verification from the LTCC for Mrs. S is not received by the 22nd day following the date of application eligibility must be determined using Mr. S's income. A determination of eligibility may not be delayed pending receipt of LTCC approval. Eligibility is determined as follows:

\$ 515	Mrs. S's SS check	\$ 750	Mr. S's pension
- 20	Unearned Income Deduction	- 20	Unearned Income Deduction
<u>\$ 495</u>		<u>\$ 730</u>	
- 440	MA Income Standard for 1	- 440	MA Income Standard for 1
<u>\$ 55</u>		<u>\$ 290</u>	
x 6		x 6	
<u>\$ 330</u>	Mrs. S's Six-Month Spenddown	<u>\$ 1740</u>	Mr. S's Six-Month Spenddown

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

5454 (con't)

## Example:

Mrs. A. has a degenerative neurological illness. She is 61 years old. Her husband is 63 and is employed full time, earning \$450 per week net. Mrs. A's illness has reached the stage where she must enter a long-term-care facility unless she receives an MA application with a LTCC Authorization Form verifying need for Level III care and receipt of home care services. Mrs. A has a \$1000 life insurance policy, shares a joint \$1500 bank account with her husband, and has no income. While the SSI application is pending, the worker makes a referral to SMRT, and Mrs. A is approved for MA/DA.

Mrs. A's application is approved for MA with no spenddown, as there is no income to be considered.



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

F5454: Long Term Care Connection Authorization Form



CHARLES M. ATKINS  
Commissioner

## *The Commonwealth of Massachusetts* *Executive Office of Human Services* *Department of Public Welfare*

Date: \_\_\_\_\_

### LONG TERM CARE CONNECTION AUTHORIZATION FORM

At the request of \_\_\_\_\_ and in accordance with the Department of Public Welfare regulations 456.251-265 the Placement Review Team of the Department's Long Term Care Connection has reviewed the application of \_\_\_\_\_ Medicaid Number \_\_\_\_\_ and finds that the client:

- ☐ Meets criteria for Level II, Skilled Nursing Services.
- ☐ Does not meet the criteria for Level II, Skilled Nursing Services.
- ☐ Meets criteria for Level III, Intermediate Care Services.
- ☐ Does not meet the criteria for Level III, Intermediate Care Services.

#### RIGHT TO APPEAL

The General Laws provide that if you are not satisfied with any action by the Department of Public Welfare, you have the right to appeal and receive a fair hearing before a referee of the Division of Hearings. The request for fair hearings must be received by the Department within sixty (60) days of the date of this written notice to you of the decision of the Department's Placement Review Team. Attached please find the Department's request for a Fair Hearing Form.

Placement Review Team Member: (Name) \_\_\_\_\_

(Signature) \_\_\_\_\_

ccc \_\_\_\_\_ (Name) \_\_\_\_\_

2176 Waiver \_\_\_\_\_ (Signature) \_\_\_\_\_

LONG TERM CARE CONNECTION

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





5460: Selection of the Assistance Unit

Under certain circumstances, an individual or family may be considered for eligibility in more than one assistance unit or category of assistance (i.e., AFDC-Related, SSI Related, and/or MA-Under 21.)

The individual or family may select the composition and categorical relatedness of the assistance unit for which he wants to be considered, and the worker shall explain the options available to him.

This is explained in this handbook in Chapter IV, Section 4140, and Chapter VI, Section 6300.



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CHAPTER VI

CALCULATION OF FINANCIAL ELIGIBILITY

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6000: OVERVIEW OF FINANCIAL ELIGIBILITY6010: Defining "Available" Income and Assets

Section 506.000 of the Policy Manual states that financial eligibility is determined by comparing the total countable assets and income "available to persons in the assistance unit" with the asset limitation and income standards established by the Department. It should be emphasized that resources available to persons in the assistance unit include not only the assets and income of the assistance unit itself but also assets and income considered by the Department to be available from members of the filing unit who have a financial responsibility (5400) but who are not themselves eligible for medical assistance.

6020: Scope of Chapter

The methods of calculating financial eligibility, as explained and illustrated in this chapter, deal with the treatment of income only.

Before applying the regulations concerning countable income and allowable deductions, the worker should already have determined that the assets of the filing unit are within the asset limitations (5110). If there are excess assets, the application must be denied, or assistance terminated, even though the income is within the Department's income standards. If there is excess income, however, the applicant is eligible if his countable medical expenses are equal to the excess income.

6030: Simplified Formula for Determining Eligibility

The simplified formula for determining whether a filing unit meets the MA income standards or has excess countable income is:

$$\begin{array}{r} \text{Total monthly income} \\ - \text{Total income deductions} \\ \hline = \text{Net MA Income} \\ - \text{MA Income Standard for Size of Filing Unit} \\ \hline = \text{Excess Monthly Income, if any.} \end{array}$$

6040: Conversion to Monthly Income

In order to compute total income, all income must be converted to monthly amounts:

If Pay Period is:	Multiply By:
Weekly	4.333
Bi-weekly	2.1665
Semi-monthly	2
	Divide by
Yearly	12
Quarterly	3

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

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## 6050: Income Deductions

Allowable income deductions differ depending upon whether the applicant/recipient is a member of an AFDC-or SSI-related filing unit, whether he is living in the community or in a long-term-care facility, and whether the income is earned or unearned.

Some deductions are applied to the income of each member of a filing unit, while others are applied to the unit as a whole. The following chart is intended as a guide which may prove helpful. Allowable deductions are discussed in detail in 6100-6220.

TABLE OF INCOME DEDUCTIONS

	Unearned Income Deductions	Earned Income Deductions W.B.E.	Dependant Care	Health Ins. Deduction	Court Ordered Support Payments	Maintenance Of Home	Allowance For Dependants
<b>AFDC-Related Filing Units</b>							
Community or Acute Care	---	Max. \$75	Max. \$160 per child	✓	✓	N/A	N/A
Long-Term- Care Fac.	---	S.D. + \$11	---	✓	✓	✓	✓
<b>SSI-Related Filing Units</b>							
Community or Acute Care	\$20	+65 + 1/2		---	---	N/A	N/A
Long-Term- Care Facility	---	S.D. + \$11	---	✓	✓	✓	✓

✓ = Allowed

--- = Not Allowed

SD = Salary Deductions





6070

6070: Income-in-Kind

When shelter, utilities, and/or food are provided to the applicant/recipient without charge, the following amounts are added to other income in computing the total countable income of the filing unit:

INCOME IN-KIND	VALUE
Shelter: Unheated Facility	\$102.00 per month per household
Shelter: Heated Facility	\$126.30 per month per household
Fuel	\$ 27.90 per month per household
Utilities	\$ 18.60 per month per household
Food	\$ 41.80 per month per individual

No portion of the above amounts is counted as income when the cost of rent, utilities or food is reduced because of subsidized housing, fuel assistance programs or food stamps. Nor is any portion counted as income when these expenses are shared with another or others.



6100: INCOME DEDUCTIONS: COMMUNITY CASES6110: Unearned Income Deductions

Unearned income is discussed in 5220 ff.

6111: AFDC Related

The only unearned income deduction allowed in AFDC-related cases is the first fifty dollars (\$50) of child support or alimony received by the assistance unit. This disregard applies only to current monthly support and may not exceed fifty dollars (\$50) per month per assistance unit. If the total monthly support is less than \$50, only the amount actually received is deductible.

EXAMPLE: Mrs. Smith is a divorced woman with two dependent children. Her only source of income is a \$500 monthly support payment that she receives from her ex-husband for the two children.

\$500.00	Support for the two children
- 50.00	Support Disregard
<u>\$450.00</u>	Net MA Income

6112: SSI-Related

A) SSI-related community-based cases are allowed an unearned income deduction of \$20 per individual or married couple.

EXAMPLE 1: Janet Foster, a single disabled adult, receives Social Security benefits of \$350.00 per month.

\$350.00	Social Security
- 20.00	SSI-related disregard for individual
<u>\$330.00</u>	Net MA Income (less than MA Standard for a Filing Unit of 1)

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

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EXAMPLE 2: George Davis, a 66 year-old widower lives with his adult son. He has just retired and has applied for his Civil Service Annuity but at present has no income. His son is not charging him room and board.

\$126.30	Shelter: Heated
41.80	Food
<u>168.10</u>	Total Income-in-Kind (or current figures from table 6070)
- 20.00	SSI-related disregard for individual
<u>\$148.10</u>	Net MA Income

NOTE: A tickler file card should be kept so that Mr. Davis can be contacted in two months if receipt of Civil Service Annuity has not been reported by that time.

EXAMPLE 3: James and Bernice Stevens are 66 and 65 years old respectively. James' Social Security benefit is \$290 per month and his wife's is \$145.00 per month.

\$290	Mr. Stevens' Social Security
145	Mrs. Stevens' Social Security
<u>\$435</u>	Total Unearned Income
-20	SSI-related disregard for couple
<u>\$415</u>	Net MA Income (less than MA Standard for a Filing Unit of 2)

NOTE: Since their income is below the SSI standard, this couple should be referred to SSI.

B) In filing units with a disabled child(ren), a deduction of \$20 is also allowed from any income deemed to each disabled child.

EXAMPLE: Bob Andrews collects \$635 per month in Social Security Disability benefits. He lives with his wife and his 18-year old son, Mark, who is also disabled and receives \$158 per month in SSA benefits. Mark attends the nearby community college.

Although Mark could apply for MA/DA on his own, the family has the option of contributing to his support in accordance with SSI regulations. That is, if Mark were to apply for SSI, a portion of Mr. Andrews' income would be "deemed" to him as in the example below. This would permit Mr. Andrews to be eligible without a spend down.



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6112

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

\$635	Total unearned income for Mr. and Mrs. Andrews
-20	Disregard for SSI related individual
<u>\$615</u>	Countable income for Mr. and Mrs. Andrews
-442	MA Standard for 2
<u>\$173</u>	Income available (deemed) to Mark
+158	Mark's Social Security benefit
<u>\$331</u>	Mark's Total Income
- 20	SSI-related disregard
<u>\$311</u>	Mark's net MA income (less than the MA Standard for a Filing Unit of 1)

Only Mr. Andrews and Mark are eligible for MA/DA: Mrs. Andrews is not disabled.

- C) One third of a child support payment paid by an absent parent on behalf of an SSI-Related child is non-countable income.

EXAMPLE: Mrs. Musgrove lives with her 16 year old disabled son, Jeremy. Jeremy receives \$200 per month RSDI for his disability and a \$240 monthly child support check from his father. Mrs. Musgrove receives \$100 monthly from a pension. There is no other income.

There are two possible ways to determine eligibility in this situation. If Jeremy is the only one in need of Medical Assistance, application for MA/DA may be made for him as an SSI-related individual.

## SSI-Related

\$100	Pension for Mrs. Musgrove
240	Child Support Payments for Jeremy
+200	RSDI for Jeremy
<u>\$540</u>	
-20	SSI Unearned Income Disregard
<u>520</u>	
- 80	(minus 1/3 of the \$240 child support payment)
<u>\$440</u>	Net MA income
-442	MA Standard for a Filing Unit of 2
<u>0</u>	No Excess Income

If Mrs. Musgrove has medical needs and does not have health coverage through her pension, it might be more advantageous to apply for MA/AFDC even though the family would have to meet a spenddown.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

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EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (CON'T)  
(6060)

## AFDC-Related

\$100	Pension for Mrs. Musgrove
240	Child Support Payment for Jeremy
+200	RSDI for Jeremy
<u>\$540</u>	
- 50	(minus first \$50 of support payment)
<u>\$490</u>	Net MA income
-442	MA Standard for a Filing Unit of 2
<u>\$ 48</u>	Excess Monthly Income

### 6113: Carry-Over of Unearned Income Deductions to Earned Income

If the unearned income of an SSI-related individual or couple residing in the community is less than \$20, the remaining portion of the \$20 may be deducted from earned income. (See 6127)

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6120

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

## 6120: Earned Income Deductions

Earned income is discussed in 5210ff.

## 6121: AFDC Related Filing Units - Work Related Expenses (WRE) Deduction

The deduction for work related expenses, that is, state and federal taxes, Social Security (FICA), union dues, and items necessary to employment such as uniforms, special shoes and tools, is \$75.00 per month for each member of the filing unit who is employed full-time or part-time, regardless of the number of hours worked.

### EXAMPLE 1:

Charles Stewart is a 20 year old carpenter's helper. His work depends partly on the weather and partly on the type of job his boss is doing - he is not always needed. Over the past five weeks Charles' hours have been:

21.5	
33.0	
14.5	
17.0	
18.5	
5)104.5	= 20.9 average hours per week
x4.333	
90.6	average hours per month

Charles' work related expense deduction is \$75.00.

### EXAMPLE 2:

Kate Nichols works 20 hours a week making salads in a local restaurant. She makes \$4.50 an hour. Her husband, from whom she is separated, pays \$50 per week for the support of their two children.

\$389.97	Gross monthly earned income
- 75.00	WRE Deduction
<u>\$314.97</u>	
+216.65	Child Support
<u>\$531.62</u>	
- 50.00	Support Disregard
<u>\$481.62</u>	Net MA Income

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6121

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

## EXAMPLE 3:

Betty Collins has 3 children. She works in her own home making slip covers and drapes. Her customers purchase their own material. Betty visits the homes of her customers to take the necessary measurements and to deliver the finished products. By terms of the divorce, her ex-husband makes the mortgage payments.

Betty's income for the past year as shown on her income tax return was as follows:

<u>MONTH</u>	<u>INCOME</u>
January	\$ 268
February	315
March	525
April	460
May	422
June	471
July	305
August	272
September	327
October	457
November	488
December	<u>603</u>
TOTAL FOR YEAR	\$4,913

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6122

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

Schedule C of Betty's income tax return shows her expenses. She charged 1/6 of the expenses of her 6-room house as a business expense since she uses her dining room exclusively for a sewing room.

## Yearly Business Expenses

1/6 of Real Estate Taxes (\$1956)	\$326
1/6 of utilities (heat, electricity, insurance, phone, water)	190
Use of car in work (1700 miles @ 20 cents per mile)	340
Advertising	90
Materials (thread, zippers, needles, pins, cording, hooks, etc.)	213
Year's Total	<u>\$1,159</u>

Betty's eligibility for MA is calculated as follows:

Gross Yearly Income	\$4,913
Business Expenses for Year	<u>1,159</u>
	3,754
Average Monthly Earned Income	313
Standard Work Related Deductions	<u>- 75</u>
Net MA Income	238
Less Than MA Standard for 4	463

## 6122: Restrictions on Allowance of WRE Deduction

### A. Refusing Employment Without Good Cause

If a member of the filing unit terminates or reduces employment or refuses a bona fide offer of employment without good cause, the work-related expense deduction is not allowed until the calendar month which begins at least 30 days after this action. The deduction is still allowed for other working members of the filing unit.



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6122

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

## EXAMPLE 1:

Mrs. Anderson has two daughters, ages 7 and 9. In August she applies for MA/AFDC because she is a diabetic and her medical insurance does not cover insulin.

Mrs. Anderson works 35 hours per week at \$4.00 per hour. This is her only income. Her mother lives with her and babysits for the two girls. Worker computes her eligibility as follows:

\$606.20	Gross monthly income
-75.00	Work related expenses (WRE)
<u>\$531.20</u>	Total MA income
-452.00	MA standard for 3
<u>\$ 79.20</u>	Excess monthly income
x 6	
<u>\$475.20</u>	Six-month spenddown

Mrs. Anderson receives an MA/NFL-8A informing her that she has a six-month spenddown of \$475.20. She calls the Department in September to inform the worker that she is now working only 30 hours per week. The worker explains to her that since she reduced her hours of employment without good cause, the \$75 WRE can not be allowed for September. Worker recomputes the spenddown as follows:

<u>September</u>		<u>October-January</u>	
\$519.60	Gross monthly income	\$519.60	Gross monthly income
-452.00	MA standard for 3	- 75.00	WRE
<u>\$ 67.60</u>	Excess monthly income	<u>\$444.60</u>	Total MA income
		-452.00	MA standard for 3
			No excess monthly income

### August-January

\$ 79.20	Excess August income (see above)
+ 67.60	Excess September income
<u>\$146.80</u>	Six-month spenddown

MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK  
EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060) }

6124-3

EXAMPLE:

Anthony and Angeline DiStephano live in Framingham. Anthony is unemployed. They have two children, Joseph aged 15 and Tony aged 13. Tony is deaf. The family moved to Framingham four years ago in order that Tony might attend the school for the deaf. Anthony is offered a job at a new plant in Springfield. Mr. DiStephano takes another job at lower pay in order to remain in Framingham. Since the commuting time to Springfield would be in excess of two hours per day (504.440 (E) (1) b.), this constitutes good cause.

B. Failure to Report Income

The \$75 work-related expense deduction is not applied for any month in which the earned income is not reported in a timely manner, that is, within ten days of the time it is received.

EXAMPLE:

Florence Baker and her four children are on MA/AFDC. She had been receiving \$115 per week unemployment compensation. Her total monthly income was \$498. (Less than the \$531 standard for five people.)

A redetermination was mailed to Mrs. Baker at the end of November. The form she returned on December 20 included three pay stubs, each showing \$175.00 gross income. When questioned about her work, Mrs. Baker stated that she began working November 20 and received her first pay December 2. The income should have been reported by December 12. Therefore the \$75.00 deduction is not applied for December.

Unreported income received earlier than the month of redetermination necessitates a referral for fraud and/or recovery (2820).

C. Rental, Roomer and Boarder Income

1. Rental Income

In AFDC-related cases the standard work-related expense deduction does not apply to rental income, even when considered as earned income.

When an apartment(s) in the applicant's/recipient's home is rented to others, actual verified costs of maintenance and repairs (not for purely cosmetic purposes) for the home may be deducted from rental income.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6122-4

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

The carrying charges and cost of heat and utilities (if provided from a single heating unit or meter) must be prorated per unit. Only the amount attributable to the rental unit(s) may be deducted as a business expense.

## EXAMPLE:

John Connors has recently lost his job. He collects \$165 per week Unemployment Compensation. John owns the three decker house in which he lives with his wife and four children. The mortgage is \$560 per month including taxes. Water is \$180 per year; insurance, \$840 per year. He rents the second and third floors for \$285 each. The tenants pay their own heat and utility bills. During the past year the toilet in the first floor unit and the kitchen sink in the third floor unit had to be replaced. There were also four plumbing bills before the replacements. The total as verified was \$720. Maintenance for the home plus two-thirds of the carrying costs may be deducted from the rental income.

### Total Monthly Carrying Costs

Mortgage and Taxes	\$560
Water 1/12 x \$180	15
Insurance 1/12 x \$840	70
Total Carrying Charges	<u>\$645</u>

2/3 of total carrying Charges	\$430
-------------------------------	-------

Actual maintenance and repairs	
1/12 x 720	60
+ Prorated Carrying Charges	430
Total deductible business expenses	<u>\$490</u>

Mr. Connor's eligibility is determined as follows:

Gross Rental Income	\$570.00
Expenses	<u>490.00</u>
Net Rental Income	80.00
Unemployment Compensation	+714.95
Total MA INcome	<u>794.95</u>
MA Standard for 6	<u>-600.00</u>
Excess Monthly Income	194.95

## 2. Income from Room and Board

In SSI-related and AFDC-related cases the standard work related expense deduction does not apply to income received from room and/or board. Instead a standard deduction for business expenses is allowed (5213).

## EXAMPLES TO SHOW THE METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS

Deductible business expense for room and board income - 75% of income

Deductible business expense for room only - 25% of income

EXAMPLE:

James Brady, age 20, inherited his parents' house when they were killed in an automobile accident. He works 15 hours a week at \$3.35 per hour. Two students live with him and pay \$25.00 per week for their rooms.

\$217.73	Gross monthly earned income ( $\$3.35 \times 15 \times 4.333$ )
<u>-75.00</u>	Standard WRE deduction
\$142.73	
<u>+162.49</u>	Income from room rent = $3/4 \times \$216.65$
\$305.22	Total MA Income
<u>455.00</u>	MA Standard
	No Excess monthly income

6123: Dependent Care Deduction

The dependent care deduction is the actual cost of care for a dependent child or an incapacitated individual in the filing unit, including the cost of transporting the dependent to and from dependent care. The maximum deduction for dependent care cannot exceed \$160 per month for any dependent in the filing unit. The portion of the \$160 allowed is based on the number of hours worked. The actual cost is used only when it is less than the amount specified in the following chart that corresponds to the number of hours worked.

<u>Weekly Hours</u>	<u>Monthly Hours</u>	<u>Maximum Deduction</u>
1 - 10	1 - 43	\$ 40
11 - 20	44 - 87	\$ 80
21 - 30	88 - 130	\$120
31 - above	131 - above	\$160



## EXAMPLES TO SHOW THE METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS

EXAMPLE 1:

Grace Durkin works 20 hours per week from 9:00 AM to 1:00 PM at \$3.50 per hour. Her husband, Frank, works 40 hours per week for a gross weekly income of \$240.00. They have two children in school and one pre-schooler who is cared for by a neighbor for \$1.50 per hour while Grace works.

<u>Frank</u>		<u>Grace</u>	
\$1040.00	Gross Monthly Income	\$303.31	
-75.00	Standard Deduction	-75.00	
<u>\$ 965.00</u>		<u>\$228.31</u>	
	Dependent Care Deduction	-80.00	(actual cost \$130.00)
		<u>\$148.31</u>	
Frank's Net MA income		\$ 965.00	
Grace's Net MA income		+ 148.31	
		<u>1113.31</u>	
MA Standard for 5		- 875.00	
Excess Monthly Income		<u>\$ 238.31</u>	

EXAMPLE 2:

Paul and Jean LeBlanc have two children ages 10 and 15. Paul works full time and earns \$255 per week. While walking on the sidewalk a few months ago, Jean was hit by a car that went out of control and was pinned against a wall, breaking her back. After many weeks in the hospital, Jean was allowed to return home with a hospital bed and other special equipment. A visiting nurse checks her each day. She cannot get out of bed and must have someone nearby at all times.

She is not expected to be incapacitated for a full year. Paul pays a woman \$75 a week to stay with her 6 hours a day while the children are in school.

\$1105.00	Paul's gross monthly income
- 75.00	Standard WRE Deduction
<u>\$1030.00</u>	
- 160.00	Dependent Care Deduction (actual cost \$325.00)
<u>870.00</u>	
- 766.00	MA Standard for 4
<u>\$ 104.00</u>	Excess monthly income



## EXAMPLES TO SHOW THE METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS

EXAMPLE 3:

Susan Jacobson pays a family day care home \$25.00 per week from her \$180 gross pay to care for her child while she works. She works 37 1/2 hours per week, Monday through Friday. Each working day she must take one extra bus trip on her way to work, and one extra bus trip on her way home from work, to drop the child off and pick the child up from the day care home. Each bus trip costs 50 cents.

Gross monthly income	\$780.00	
Standard WRE deduction	- 75.00	
	<u>\$705.00</u>	
Dependent Care Deduction	-130.00	(actual cost \$130.00:
Net MA Income	<u>575.00</u>	\$108.33 Child Care
MA Standard for 2	-550.00	+ 21.67 Transportation
Excess monthly income	<u>\$ 25.00</u>	<u>\$130.00</u> Total Dependent Care Expense)

6124: Restriction on Dependent Care Deduction

If a member of a filing unit reduces income by requesting fewer hours or pay at a lower rate, or if the individual quits his or her job without good cause (4448) or refuses a bona fide offer of employment (4447), no dependent care deduction is allowed until the calendar month that begins at least 30 days after this action.

EXAMPLES: See 6122 A.

NOTE: Judgment must be exercised carefully in determining whether or not a parent has good cause for terminating or decreasing employment when child care is involved.

6125: Verifications Necessary for Dependent Care Deduction

The amount paid for dependent care must be verified by a signed and dated statement by the person or agency providing the care or by a cancelled check or money order payable to the provider. When none of the above documents are available, the amount paid for dependent care must be verified by a signed and dated statement by the employed individual of the dependent care expenses incurred.

The cost of transporting dependents to and from dependent care must be verified by a signed and dated statement from the employed individual showing the actual cost of this transportation.

When a dependent care deduction is claimed for an incapacitated individual, the incapacity must be verified by a current statement from a competent medical authority, as defined in 106 CMR 501.500(J).



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6126

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

## 6126: Application Of \$30 And 1/3 Earned Income Disregards To MA/AFDC And MA/21.

When an AFDC recipient has earned income, the first \$30 and the next one-third of gross income are disregarded for four months. Only the first \$30 is disregarded for the next five to twelve months.

The first \$30 and next one-third of gross earned income must also be disregarded if a family or individual applying for MA/AFDC or MA/21 received AFDC cash assistance in any one of the four calendar months immediately prior to application for Medical Assistance. Only the first \$30 must be disregarded if a family or individual applying for MA/AFDC or MA/21 received AFDC cash assistance in any one of the five to twelve prior calendar months.

The one-third disregard is not applied to the earnings of individuals or families who have already received an extended period of guaranteed Medical following their termination from cash assistance. The \$30 disregard is applied for the balance of the twelve-month period following termination of cash assistance.

### Verifying the Termination Period

When terminating a case, the date of closing and the action reason to be used should be checked to see whether there was an automatic extension of MA benefits and the length of the extended period.

If an application for MA shows that the applicant is a former recipient of AFDC, the VDT screen should be used to determine the date of closing and the action reason.

In MA/21 cases, the workers must be alert for those former AFDC recipients who have earned income although they were terminated for other reasons.

### Applying the Personal Eligibility

Since the one-third earned income disregards may never be applied for a full six-month eligibility period, the result of the application of this policy in most cases will be to reduce the spenddown rather than to make the individual immediately eligible for Medical Assistance.

### EXAMPLE 1:

The Lee family consists of a husband, wife, and three children. After receiving AFDC during April and the first half of May, Mr. Lee obtains a full time job, and requests that his AFDC and MA case be terminated. (The family had not received AFDC long enough to be eligible for the four-month automatic extension of medical benefits following a termination of AFDC for reasons of increased earnings or increased hours of employment.)

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6126

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

In June Mr. Lee applies for MA primarily for dental bills not covered by his insurance. The six month eligibility period is established as June through November. AFDC cash assistance was last received in May; therefore the \$30 and one-third disregards are applied to earned income received in June, July, August, and September. The family could no longer meet the criterion of having received AFDC in one of the past four months in October and November, but could meet the criterion of having received AFDC in one of the past 12 months. A separate calculation is required allowing only the \$30 disregard for the spenddown amount for these two months.

Mr. Lee's gross income is \$195 per week, or \$844.94. Eligibility is determined as follows:

<u>For June through September</u>		<u>For October and November</u>	
\$844.94	Gross Monthly Income	\$844.94	
-75.00	WRE Deduction	-75.00	
<u>\$769.94</u>		<u>\$769.94</u>	
-30.00	Disregard	-30.00	
<u>3) 739.94</u>		<u>\$739.94</u>	
-24.00	Disregard		
<u>495.94</u>	Net MA Income		
-531.00	MA Exemption for 5	-531.00	
<u>\$</u>	Excess monthly income	<u>208.94</u>	
	Spend-down for 4 months = 0.00	x 2	
	Spend-down for 2 months = 417.88	<u>\$417.88</u>	(Spenddown for October and November)
	<u>Spend-down for 6 months = 417.88</u>		

The family's total six month spenddown is \$417.88. Responsibility for dental bills in this amount must be met before the case is entered in the Recipient Master File.

At the spenddown is met for June through November, if the Lees re-applied at any time before the following June, they would be entitled to the \$30 disregard through May.

## EXAMPLE 2:

The Jones family also consists of a husband, wife, and three children. The family received AFDC in February and March. Mr. Jones returned to work on March 23 and requested in writing that his AFDC and MA be terminated. His last AFDC check was dated March 17. The family had no medical bills in April or May.

In June, however, Mr. Jones applies for Medical Assistance. The six-month eligibility period is established as June through November. Since the last AFDC check was received in March, the \$30 and one-third disregards are used for June and July, and the \$30 only disregard is used for August, September, October and November.

Mr. Jones's gross income is \$250 per week or \$1,083.25 per month.



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6127

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

## 6127: SSI-Related Filing Units

The standard deduction from gross earned income in an SSI-related filing unit is \$65 plus one-half of the remainder. If there is less than \$20 unearned income in the filing unit, any remaining part of the \$20 unearned income deduction (6110) is taken from the gross earned income before the \$65 and 1/2 earned income deductions.

### EXAMPLE 1:

Margaret and Henry Gibson, ages 59 and 66 respectively, have several sources of income. Margaret works as a domestic and receives \$160 monthly. Henry receives a \$316.40 Social Security benefit monthly as well as a quarterly stock dividend of \$78.00.

\$316.40	Social Security
+26.00	1/3 quarterly stock dividend
<u>\$342.40</u>	Total unearned income
-20.00	SSI-Related Disregard
<u>\$322.40</u>	Net unearned income
\$160.00	Gross Earned Income
-65.00	SSI-Related Earned Income Deduction
2) <u>95.00</u>	
-47.50	(minus 1/2 of remainder)
<u>\$47.50</u>	Net earned income
\$322.40	Net Unearned Income
+47.50	Net Earned Income
<u>\$369.90</u>	Net MA Income (less than \$442)

Only Henry is eligible, however, because Margaret is under 65 and has not been determined to be disabled.

### EXAMPLE 2:

Ann Appleby, a single disabled adult, receives a voluntary contribution from her sister of \$15.00 monthly. She works at a sheltered workshop for a gross monthly salary of \$519.60.

\$ 15.00	Unearned income
- 20.00	SSI-Related Unearned Income Deduction
<u>\$ 5.00</u>	
\$519.60	Earned Income
- 5.00	Balance of \$20.00 Deduction
<u>\$514.60</u>	
- 65.00	SSI-Related Earned Income Deduction
2) <u>449.60</u>	
-224.80	Minus 1/2 of remainder
<u>\$224.80</u>	Net MA Income (less than \$350)

She is eligible for MA/DA.



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

. 6126.

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

Eligibility is determined as follows: .

<u>For June and July</u>	<u>For August through November</u>
\$1083.25 Gross monthly income	\$1083.25
- 75.00 WRE deduction	- 75.00
<u>1008.25</u>	<u>1008.25</u>
- 30.00	- 30.00
<u>978.25</u>	<u>978.25</u>
- 326.08	
<u>652.17</u>	
- 531.00 MA Standard for 5	-531.00
<u>121.17</u> Excess monthly income	<u>447.25</u>
x 2 months	x 4 months
\$ 242.34 Spenddown for 2 months	\$1,789.00
+1789.00 Spenddown for 4 months	
<u>\$2,031.34</u> Total six-month spenddown	

Responsibility for medical bills in this amount must be met before the case is entered on the Recipient Master File. Since the family last received AFDC cash assistance in March, the following March is the last month they would be eligible to receive the \$30 disregard.

## EXAMPLE 3:

George Green, aged 18, had been included in his mother's AFDC grant until he completed a technical course in June. He then obtained a job in another town and moved in with his married sister, paying room and board. George did not return his MAOA redetermination form and his MA was terminated on July 31. He reapplies for MA in August.

George earns \$5.00 an hour but works only a 30-hour week. The four-month period after receipt of AFDC ends in October, the twelve month period ends in June. Eligibility is determined as follows:

<u>Aug., Sept., &amp; Oct.</u>	<u>Nov., Dec., &amp; Jan.</u>
\$650.00 Gross monthly income	\$650.00
- 75.00 WRE deduction	- 75.00
<u>\$575.00</u>	<u>\$575.00</u>
- 30.00 Disregard	- 30.00
<u>3)545.00</u>	<u>545.00</u>
-181.66 Disregard	
<u>363.34</u>	
-350.00 MA Standard for 1	-350.00
<u>\$ 13.34</u>	<u>\$195.00</u>
x 3 3 month spenddown	x 3
\$ 40.02 3 month spenddown	\$585.00 = 3 month
+585.00 3 month spenddown	spenddown
<u>\$625.02</u> Total six-month spenddown	

George is ineligible for MA unless he has medical bills in August through January of at least \$625.02.  
MA-TN # 100 (12/19/84)

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6127

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

## EXAMPLE 3:

Martin Hughes, age 66, has not yet retired from his full-time job as a janitor. His gross monthly salary is \$803.00. He has a health insurance premium of \$12.00 deducted from his bi-weekly pay check. The Social Security Administration has determined that Mr. Hughes is not eligible for benefits at this time.

\$803.00	Gross Earned Income
- 20.00	Deducted from Earned Income because
<u>783.00</u>	there is no Unearned Income
- 65.00	SSI-Earned Income Deduction
2) <u>718.00</u>	
-359.00	Minus 1/2 of remainder
<u>\$359.00</u>	Net MA Income
-350.00	MA Income Standard
<u>\$ 9.00</u>	Excess monthly income

In SSI-related cases the cost of health insurance is not treated as an earned income deduction, but the cost of premiums, when verified, is applied toward the applicant's spend-down liability. In Mr. Hughes case the cost of his health premiums would exceed his spend-down liability and he would be eligible for assistance immediately.

## EXAMPLE 4:

Harvey Riggs, age 58, had a stroke on May 17 which left him "permanently and totally disabled". On May 29, his wife filed an application for Medical Assistance. The total gross income that Mr. Riggs received in May was \$376.23. (This includes his final pay check.) Mrs. Riggs, age 55, earns a gross monthly salary of \$682.45. There is no unearned income at this time.

6) <u>\$376.23</u>	Mr. Riggs' earnings prorated over 6 months. He will have no further income.
62.70	
-20.00	No unearned income: deducted from earned income
<u>\$42.70</u>	Mr. Riggs' countable earned income
+682.45	Mrs. Riggs gross earned income
<u>725.15</u>	Filing unit's earnings after \$20 deduction
-65.00	SSI-Related Earned Income Deduction
2) <u>660.15</u>	
-330.07	Minus 1/2 of remainder
<u>\$330.08</u>	Net MA Income (less than \$442)

Only Mr. Riggs is categorically eligible for assistance. He must be informed that any insurance or disability benefits are to be reported within ten days after receipt and that eligibility will be redetermined at that time.



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6130

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

## 6130: General Income Deductions

There are no general income deductions for SSI-related community cases. All deductions are incorporated in the \$20-\$65-1/2 from gross income formula (6110 and 6128).

## 6131: Deduction for Health Insurance Premiums in AFDC-Related Cases

A deduction is allowed over and above the \$75.00 standard work-related expense deduction when health insurance or membership in a health maintenance organization (HMO) is deducted from the pay check. Verification is by a copy of the pay check showing the deduction or by a statement from the employer. Health insurance premiums paid directly by the applicant/recipient to the insurer are used to meet a spenddown liability, if any, (6500).

### EXAMPLE:

Lois Landry supports her two children by working full time as a cook. Her gross monthly salary is \$600. Her employer offers a health plan that covers her free of charge, but in order to cover the children, she must have an extra \$15 per month deducted from her pay. Lois pays her next door neighbor \$20.00 per week to take care of the children after school.

\$600.00	Gross monthly salary
<u>-75.00</u>	Work related expenses
525.00	
<u>-86.67</u>	Actual cost of dependent care
438.33	
<u>-15.00</u>	Health insurance deduction
\$423.33	Net MA Income (less than \$452 MA standard for 3)

## 6132: Deduction for Support Payments

In AFDC-related filing units child support and alimony payments made in compliance with a court order or as the result of an agreement with the Department's Child Support Enforcement Unit are deducted from either earned or unearned income.

In order to receive a deduction for child support payments, the applicant/recipient in an AFDC-related filing unit must be

- A. under court order or agreement with the Department to pay the support; and
- B. actually making the support payments.

Being obligated to pay support is not enough; nor is paying the support voluntarily however regular the payments may be. Both conditions must be met.



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6132

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

Verification is by means of:

- A. a copy of the court order or CSEU agreement, and
- B. copies of the cancelled checks for the past two months, or a statement from the ex-spouse confirming that support payments are being made regularly. If support is paid through a probation office, a letter from the probation officer; if paid to the Department, a statement from a support worker.

## EXAMPLE 1:

Harry Turner is unemployed. He is supporting his current wife and three children on unemployment benefits of \$129.90 weekly. He is also sending \$50.00 monthly to his child from a previous marriage, and has verified this with the divorce decree and a statement from his ex-wife.

\$559.82	Total gross monthly income (\$129.90 x 4.333)
- 50.00	Court-ordered payment
<u>\$509.82</u>	Net MA Income (less than \$531 exemption for 5)

Mr. Turner, his wife, and the three children are eligible for MA-AFDC with no spend-down.

## EXAMPLE 2:

Carl Johnson is a single parent. He is supporting one child who is living with him, and he is supposed to be sending child support payments to his ex-wife for his other child. His employer has recently cut back his hours to 20 weekly, so he has stopped paying the \$75.00 monthly support. His current gross monthly salary is \$615.

\$615.00	Gross monthly income
- 75.00	AFDC-Work Related Expenses
<u>540.00</u>	
- 80.00	Dependent Care Deduction
<u>460.00</u>	Net MA Income
-442.00	MA Income Standard for 2
<u>\$ 18.00</u>	Excess monthly income

If Mr. Johnson resumed his court-ordered support payments and verified these payments, he and his son would be eligible for medical assistance with no spenddown.

He has the right to be informed of this fact in case either he or the child has serious medical problems.



6200: INCOME DEDUCTIONS: LONG-TERM-CARE CASES

THERE ARE NO UNEARNED INCOME DEDUCTIONS FOR LONG-TERM-CARE CASES.

6210: Earned Income Deductions

The majority of long-term-care cases with earned income are residents of Intermediate Care Facilities for the Mentally Retarded (ICF/MRs). ICF/MR cases are handled by the Special Medicaid Unit at 43 Hawkins St., Boston. Some residents of nursing homes and chronic hospitals, however, also have earned income and are the concern of the eligibility worker in the local office.

6211: SSI-Related Filing Units

SSI-related residents of long-term-care facilities are allowed a standard deduction of \$11.00 plus the actual payroll deductions for federal and state taxes, Social Security tax (FICA) or other retirement deductions, health insurance and union dues. No deduction is allowed for transportation or uniforms.

EXAMPLE:

Gerry Alden lives in a community based home for the mentally retarded. She earns \$75 per week at a sheltered workshop. The combined taxes come to \$19.00 per week. She pays no health insurance or union dues.

\$325.00	Gross monthly earned income
-11.00	Standard Deduction
<u>314.00</u>	
-82.33	Taxes
<u>\$231.67</u>	Net MA Income
-40.00	MA Standard for Long-Term Care
<u>\$191.67</u>	Excess monthly income

The excess monthly income is paid to the facility toward the cost of her care. If her transportation costs are more than the standard \$11.00 deduction for work-related expenses, they must be taken from her \$40 per month personal needs money (6320).

6212: AFDC-Related Filing Units

AFDC-related residents of long-term-care facilities are allowed a maximum deduction of \$75 for all work-related expenses, depending on the number of hours worked as in 6121. This is a very unlikely situation.

6224: Home Maintenance Allowance

When an MA applicant or recipient is expected to be in a long-term-care facility for less than seven months, he is allowed to retain income to maintain his home in the community. He must submit a statement from a competent medical authority verifying the expected return to the home before the end of the sixth full calendar month.

If the recipient does not return home by that time, the deduction terminates, even though he may be expected to return home in the near future.

The applicant or recipient must verify the expenses necessary to maintain the home. The amount that the applicant or recipient is allowed to retain may be the actual cost of maintaining the home or the MA standard for one person in the community, whichever is less.

Example 1:

Marie Silva, a widow, is in a nursing home recuperating from a broken hip. Her doctor has stated in writing that he expects her to be able to return home in four months. Her monthly income is \$700. The rent for her apartment is \$450 including heat and utilities.

\$700.00	Total income
- 72.80	PNA
<u>\$627.20</u>	
- 450.00	Deduction for home
<u>\$177.20</u>	Monthly PPA

Example 2:

Frank O'Brien is in a skilled nursing facility. His doctor has stated in writing that he should return home within six months. His social security check is \$450 monthly, and his pension is \$467.00. His mortgage and taxes come to \$400 per month, and water and sewer charges average \$25 per month. In addition, he will need to have some heat turned on during at least two of the months he is in the nursing facility. The cost of heat will be about \$80 per month.

\$400.00	Mortgage
25.00	Water and sewer
+ 80.00	Heat
<u>505.00</u>	Cost of home maintenance
\$450.00	Social security
+ 467.00	Pension
<u>\$917.00</u>	Total income
- 72.80	PNA
<u>\$844.20</u>	
- 483.00	Deduction for home (MA community standard is less)
<u>\$361.20</u>	Monthly PPA

6225: Health Care Coverage and Other Incurred ExpensesA. Health Insurance Premiums or Membership Costs

When the cost of health insurance premiums or HMO membership fees is deducted from the individual's pay check, that cost is allowed as a deduction in addition to the other work-related expense deductions described in Sections 6210 through 6212 for AFDC-related cases.

Health insurance premiums and HMO membership fees that the recipient pays directly to the insurer are allowed as deductions for both AFDC and SSI-related cases in determining the monthly patient paid amount.

Payment of health insurance premiums or HMO membership must be verified by copying the receipt, cancelled check, bill marked "paid," or statement from the insurance carrier (such as an explanation of benefits showing insurance payment on a recent bill). To average the cost over the six-month redetermination period, presume, based on proof of payment for the current quarter, that next quarter's premium will be paid.

Example:

Mrs. Blake, a nursing home resident, receives \$450 per month in social security benefits and \$150 per month from a private pension. She has produced proof of payment of a \$156.96 Medex payment on September 20 for October through December. Her case is being redetermined in October.

6224 (cont.)

\$450.00	Social security
+ 150.00	Pension
<u>\$600.00</u>	Total unearned income
- 72.80	PNA
<u>\$527.20</u>	Net MA income
- 52.32	Monthly Medex premium
<u>\$474.88</u>	Monthly PPA

## B. Incurred Expenses

The Department will deduct expenses incurred for necessary medical or remedial care from the applicant's or recipient's monthly income. These expenses cannot be payable by Medicaid or any other third-party insurer. They may include, but are not limited to, eyeglasses, vitamins, hearing aids, dentures, and certain medical supplies.

Expenses will be considered for deduction if:

- (1) they are not already covered by the per diem rate Medicaid pays the long-term-care facility (for example, diapers for incontinent adults are covered by the per diem rate and, therefore, would not be an allowable deduction); and
- (2) the applicant or recipient provides verification from his or her doctor that the medication, equipment, or remedial care was medically necessary. Verification may be a physician's prescription or signed statement indicating the length of time the medical or remedial care is needed. In addition, the applicant or recipient must provide a bill or receipt for the purchase. This bill or receipt should include the name of the item or service, the provider's name and address, the date, and the cost.

Review the applicant's or recipient's health insurance coverage to ensure that these expenses will not be paid by Medicaid or any other insurer. You may determine that the insurer will not cover the expense by:

- (1) having the client provide a rejected claim for the expense from the insurer;
- (2) having the client obtain a statement from the insurer stating that the expense is not covered;
- (3) reviewing the insurer's coverage booklet; or
- (4) calling the insurer.



6224 (cont.)

These expenses are applied against the applicant's or recipient's monthly patient paid amount. Adjust the PPA prospectively as soon as possible once the recipient submits the verifications. If the expense is not recurring, make the adjustment and review the case the next month to return the PPA to the original amount. If the expense is recurring, (monthly--even if for only a few months), adjust the PPA and review the case when the deduction no longer applies. Expenses may be incurred on or after the client's Medicaid eligibility date.

Example 1:

In December, Mrs. Blake loses her eyeglasses. She spends \$175 to replace them. Medicaid will not pay for her glasses since they are her third replacement this year. Mrs. Blake has no other insurance coverage. On January 5, her worker receives a "paid" receipt for the glasses and her doctor's statement that she needed to have the glasses replaced. Determine Mrs. Blake's PPA for February.

(Income is from the previous example.)

\$600.00	Income
- 72.80	PNA
<u>527.20</u>	
- 52.32	Medical deduction (Medex)
<u>474.88</u>	
-175.00	Incurred expense (glasses)
<u>\$299.88</u>	PPA for February

In March, if Mrs. Blake has no other incurred expenses, readjust her PPA to \$474.88 (original amount). If she has another expense, recalculate the PPA.

Example 2:

In April, Mrs. Blake's doctor informs her that she will have to take over-the-counter medication daily to control her heart condition. Her medication costs \$15 per month. She will be on this medication for at least six months. Mrs. Blake has provided you with her doctor's statement and bill from the pharmacy. Determine Mrs. Blake's new PPA.

\$474.88	Current PPA
- 15.00	Monthly cost of medication
<u>\$449.88</u>	New PPA

At redetermination, reverify Mrs. Blake's need for the medication and its cost.

6225 (cont.)

\$450.00	Social security
+ 150.00	Pension
<u>\$600.00</u>	Total unearned income
- 72.80	PN
<u>\$527.20</u>	Net MA income
- 52.32	Monthly Medex premium
<u>474.88</u>	Monthly PPA

B. Incurred Expenses

The Department will deduct expenses incurred for necessary medical or remedial care from the applicant's or recipient's monthly income. These expenses cannot be payable by Medicaid or any other third-party insurer. They may include, but are not limited to, eyeglasses, vitamins, hearing aids, dentures, and certain medical supplies.

Expenses will be considered for deduction if:

- (1) they are not already covered by the per diem rate Medicaid pays the long-term-care facility (for example, diapers for incontinent adults are covered by the per diem rate and, therefore, would not be an allowable deduction); and
- (2) the applicant or recipient provides verification from his or her doctor that the medication, equipment, or remedial care was medically necessary. Verification may be a physician's prescription or signed statement indicating the length of time the medical or remedial care is needed. In addition, the applicant or recipient must provide a bill or receipt for the purchase. This bill or receipt should include the name of the item or service, the providers's name and address, the date, and the cost.

Review the applicant's or recipient's health insurance coverage to ensure that these expenses will not be paid by Medicaid or any other insurer. You may determine that the insurer will not cover the expenses by:

- (1) having the client provide a rejected claim for the expenses from the insurer;
- (2) having the client obtain a statement from the insurer stating that the expenses are not covered;
- (3) reviewing the insurer's coverage booklet; or
- (4) calling the insurer.

6225 (cont.)

These expenses are applied against the applicant's or recipient's monthly patient paid amount. Adjust the PPA prospectively as soon as possible once the recipient submits the verifications. If the expense is not recurring, make the adjustment and review the case the next month to return the PPA to the original amount. If the expense is recurring, (monthly--even if for only a few months), adjust the PPA and review the case when the deduction no longer applies. Expenses may be incurred on or after the client's Medicaid eligibility date.

Example 1:

In December, Mrs. Blake loses her eyeglasses. She spends \$175 to replace them. Medicaid will not pay for her glasses since they are her third replacement this year. Mrs. Blake has no other insurance coverage. On January 5, her worker receives a "paid" receipt for the glasses and her doctor's statement that she needed to have the glasses replaced. Determine Mrs. Blake's PPA for February.

(Income is from the previous example.)

\$600.00	Income
- 72.80	PNA
<u>527.20</u>	
- 52.32	Medical deduction (Medex)
<u>474.88</u>	
-175.00	Incurred expense (glasses)
<u>\$299.88</u>	PPA for February

In March, if Mrs. Blake has no other incurred expenses, readjust her PPA to \$474.88 (original amount). If she has another expense, recalculate the PPA.

Example 2:

In April, Mrs. Blake's doctor informs her that she will have to take over-the-counter medication daily to control her heart condition. Her medication costs \$15 per month. She will be on this medication for at least six months. Mrs. Blake has provided you with her doctor's statement and bill from the pharmacy. Determine Mrs. Blake's new PPA.

\$474.88	Current PPA
- 15.00	Monthly cost of medication
<u>\$449.88</u>	New PPA

At redetermination, reverify Mrs. Blake's need for the medication and its cost.

6300: CHOICE OF ASSISTANCE UNIT

In many situations there are several possible filing and assistance units. An individual cannot be required to be part of an assistance unit, but may be required to be part of a filing unit.

When there is a choice, the category of assistance for which a family or individual should apply will depend on the medical needs of each individual compared to the difference in the spenddown that must be met when that individual is included in the assistance unit. The worker has the obligation to inform applicants and recipients of the various options available to them. (See 4140 and 6544.)



6310 EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

6310: Families with an SSI-Related Parent

If a family has a parent who is elderly or disabled, they may apply for MA/AFDC for the entire family, or may apply for MA/DA or MA/OAA for the SSI-related parent and MA/AFDC or MA/21 for the other family members.

EXAMPLE 1: Single Parent/SSI Related

Richard Quinn, a disabled widower, receives RSDI Benefits of \$380.00 monthly. He also receives \$190.00 for his 14 year old son, Lloyd.

Richard may apply for MA/AFDC for himself and his son, comparing the total of both incomes to the MA standard for two. (He could choose to apply for MA-21 for his son alone, but both incomes would still be counted since parents are financially responsible for their children.)

AFDC-Related Parent and One Child

\$380.00	RSDI for Richard
\$190.00	RSDI for Lloyd
<u>\$570.00</u>	Total Monthly Income
-\$442.00	MA Standard for 2
<u>\$128.00</u>	Excess Monthly Income

Since Lloyd is not financially responsible for his father, Richard has the option of applying for MA/DA for himself. Only Richard's income counts in making a determination of eligibility.

SSI-Related Parent

\$380.00	Total Monthly Income
-\$ 20.00	SSI-related Disregard
<u>\$360.00</u>	Net MA Income
-\$350.00	MA Standard for 1
<u>\$10.00</u>	Excess Monthly Income

In deciding whether to apply for himself alone or for himself and his son, Richard should consider if Lloyd's medical needs are greater than the additional spenddown liability.



EXAMPLE 2: Two Parent Family/SSI-Related

Barry Bates is a disabled veteran who resides with his wife, Brenda, and their two minor children. The family's only source of income is a Veterans Administration disability pension received by Barry in the amount of \$700 per month. Based upon a breakdown of the pension by the VA, \$400 of the total is for Barry, \$200 is for Brenda and \$50 for each child. The State Medical Review Team has determined that Barry is permanently and totally disabled.

Barry may apply for MA/AFDC for himself, Brenda and the two children, or he may apply for MA/DA for himself. If Barry chooses to be a separate MA/DA assistance unit, Brenda and the two children could apply for MA/AFDC, but Barry's income must be counted.

AFDC-Related Assistance Unit for Entire Family

\$400	Barry's share of VA pension
200	Brenda's share of VA pension
100	Both children's share of VA pension
<u>\$700</u>	Total Unearned Monthly Income
-509	MA Standard for Filing Unit of 4
<u>\$191</u>	Excess Monthly Income

SSI-Related Assistance Unit for Barry Only

\$400	Barry's share of VA pension
200	Brenda's share of VA pension
<u>\$600</u>	Total Unearned Income
- 20	SSI-Related Disregard
<u>580</u>	
-442	MA Standard for Filing Unit of 2
<u>\$138</u>	Excess Monthly Income

When determining eligibility for Brenda and the two children, Barry's income must be included because his income is also countable. The income is compared to the MA standard of 4.

Since Barry's and Brenda's income are counted in each filing unit, their medical bills may be applied against each spenddown. The children's medical bills may be applied only to the AFDC-related unit's spenddown.

See Section 6544.

When Brenda becomes employed part-time, her gross weekly earned income is \$75 and her monthly share of the pension is reduced by the Veteran's Administration to \$100. Using the appropriate unearned and earned income deductions, eligibility is determined as follows:

AFDC-Related Assistance Unit for Entire Family

\$400	Barry's share of VA pension
100	Brenda's share of VA pension
+100	Both children's share of VA pension
<u>\$600</u>	Total Unearned Monthly Income
+324.97	Brenda's Monthly Earned Income (\$75x4 1/3)
<u>\$924.97</u>	
- 75.00	Work Related Expense
<u>\$849.97</u>	Net Monthly Income
-509.00	MA Standard for Filing Unit of 4
<u>\$340.97</u>	Excess Monthly Income

Although the other members of the family would have a large spenddown, if Barry applies himself for MA/DA, he will have a smaller spenddown.

SSI-Related Assistance Unit for Barry Only

\$400	Barry's share of VA pension
+100	Brenda's share of VA pension
<u>\$500</u>	Total Monthly Unearned Income
- 20	SSI-Related Disregard (Unearned)
<u>\$480</u>	Barry and Brenda's Net Monthly Unearned Income
 \$324.97	 Brenda's Monthly Earned Income (\$75x4 1/3)
-65.00	SSI-related disregard-Earned Income (minus \$65)
<u>\$259.97</u>	
-129.98	SSI-related disregard-Earned Income (minus 1/2 remainder)
<u>\$129.99</u>	Brenda's Net Monthly Earned Income
+480.00	Net Monthly Unearned Income
<u>\$609.99</u>	Total Countable Monthly Income
-442.00	MA Standard for 2
<u>\$167.99</u>	Excess Monthly Income

6320: Exclusion of Child From Assistance Unit

Jean Gordon has three children, Tim aged 14, Lisa aged 9, and Louise aged 7. Tim receives \$180 per month RSDI because his father is deceased. Mrs. Gordon receives \$250 per month from her husband, from whom she is separated, for the support of Lisa and Louise.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6320

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

Mrs. Gordon works 3 evenings a week, 8 hours per evening, as an LPN at a nearby nursing home. She pays a friend \$10 per evening for child care. She herself earns \$32.00 per evening.

\$416.00	Total Monthly Earned Income (13 x \$32.00)
<u>-75.00</u>	WRE Deduction
\$341.00	
<u>-130.00</u>	Dependent Care Deduction - \$65 each Louise & Lisa
\$211.00	Countable Earned Income
<u>+250.00</u>	Support from Mr. Gordon
\$461.00	
<u>-50.00</u>	Child Support Disregard
\$411.00	Net MA income for Mrs. Gordon and 2 girls
<u>+180.00</u>	RSDI for Tim
\$591.00	MA income for entire family
<u>-509.00</u>	MA standard for 4
\$ 82.00	Excess Monthly Income

Since Tim is not financially responsible for his mother or sisters, his inclusion in the assistance unit is optional. Without Tim, eligibility is determined as follows:

\$411.00	Net MA Income for Mrs. Gordon and 2 girls
<u>-497.00</u>	MA Standard for 3
.00	No Excess Income

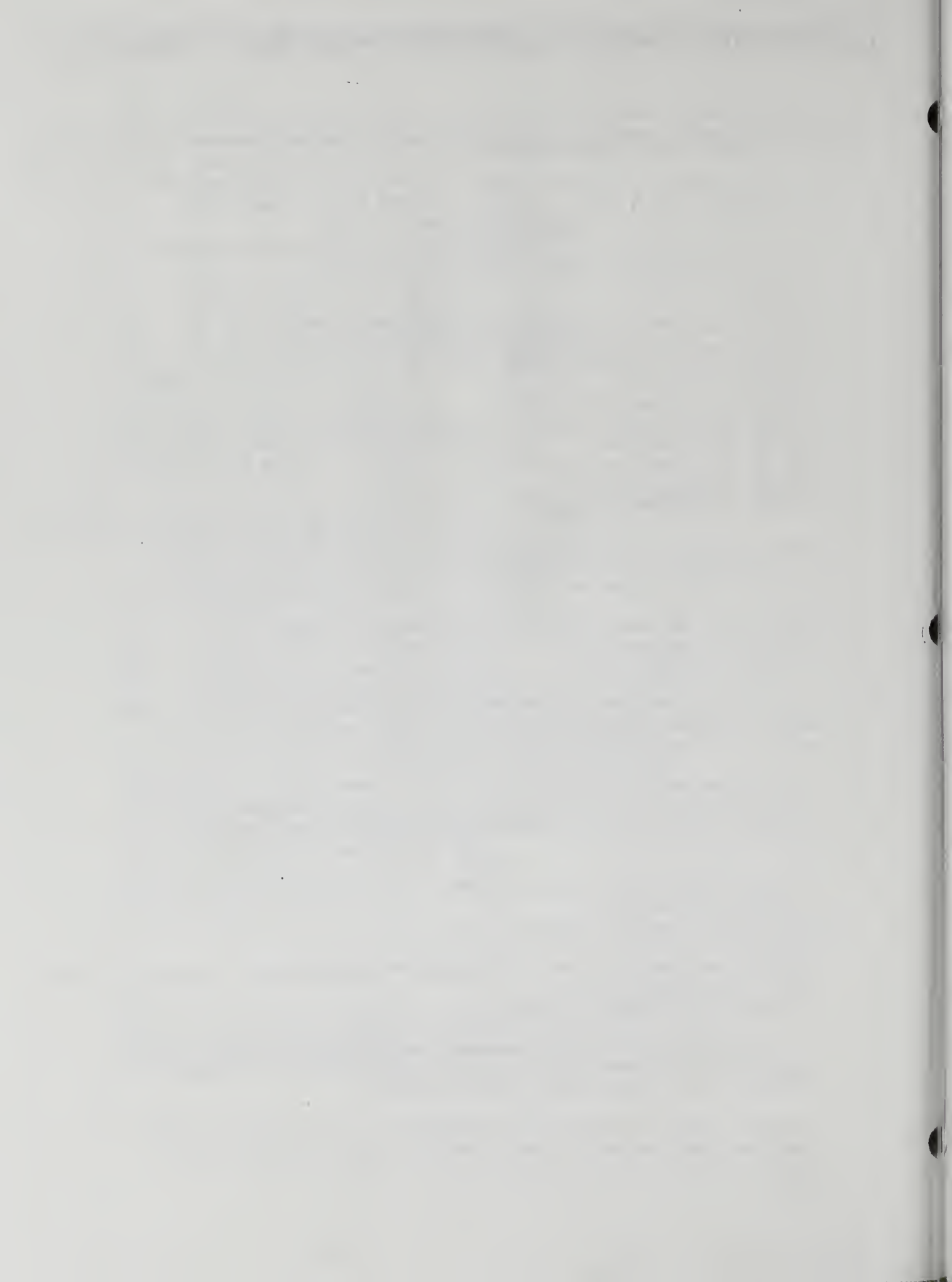
If Tim's Medical expenses tend to average more than \$82.00 per month, he should probably be included in the assistance unit even though there would be a spenddown liability.

There is one more option available which in some situations might be a viable alternative. Although Mrs. Gordon's earnings must be counted in determining Tim's eligibility, Lisa and Louise are not responsible for him.

\$416.00	Total Monthly Earned Income
<u>-75.00</u>	WRE Deduction
\$341.00	Mrs. Gordon's Income
<u>+180.00</u>	Tim's RSDI
\$521.00	Net Monthly Income for Mrs. Gordon and Tim
<u>-442.00</u>	MA Standard for 2
\$ 79.00	Excess Monthly Income

This option would not be advantageous in this particular case. However, if the payments for the girl's child support were higher this might be the best choice for the family.

The most important point to be remembered is that the medical needs of each individual as well as the financial factors should be considered when determining the make-up of a filing and/or assistance unit.



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

06330

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

## 6330: Remarried Mother-in-Need

Edna Tibbetts has three children by a previous marriage. She receives \$225 child support monthly from her ex-husband, George Balch. Edna and her present husband, Scott, have one child, Brian. Scott has been laid off and is collecting Unemployment Compensation of \$136 per week.

While Scott was working, the three Balch children received MA/21 since their total income was \$225. (Edna had no income, and Scott was not responsible for them.)

Edna now has medical bills that the family cannot afford because Scott's health insurance terminated with his employment.

If this family were to apply as one unit, they would have a large monthly excess.

\$589.33	Unemployment Compensation
225.00	Child Support
<u>\$814.33</u>	Total MA Income
-50.00	Child Support Disregard
<u>\$764.33</u>	Total MA income
-660.00	MA Standard for 6
<u>\$104.33</u>	Excess Monthly Income

Edna, however, may apply for MA/AFDC for herself and the Balch children as a remarried mother in need. Scott is responsible first for himself and his son Brian. After provision is made for them, any income left is considered available to Edna:

\$589.33	Scott's Income
-442.00	MA Standard for 2
<u>\$147.33</u>	Available Income for Edna
+225.00	Child Support
<u>\$372.33</u>	
-50.00	Child Support Disregard
<u>\$322.33</u>	Total Income for Edna and Balch Children
-509	MA Standard for 4

The MA/21 case for 3 is terminated and an MA/AFDC case for four is opened.





EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6080)

6520: Calculating the Spenddown Liability

The Spenddown liability is the amount of excess income a filing unit is expected to have available to meet medical expenses over the six-month spenddown period.

It is determined by multiplying by six the anticipated excess monthly income based on the actual income received during the most recent five weeks.

When retroactive coverage is requested, the actual income received is used for the retro period, and the anticipated excess monthly income is multiplied by the number of months remaining in the spenddown period.

The two figures are then added.

EXAMPLE 1:

Mr. Morgan, (6510 Example 1) was receiving the same income during the retroactive months (January, February and March) as during the prospective months, (April, May and June); his spenddown is determined as follows:

\$375.00	Total monthly income
<u>-20.00</u>	SSI disregard
355.00	Net MA income
<u>-350.00</u>	MA income standard
5.00	Excess monthly income
<u>x6</u>	
\$30.00	Six-month spenddown liability

EXAMPLE 2:

Theresa Moore (6510 Example 2) did not request retroactive coverage. Her weekly income is \$145. Thirty-two dollars per month is deducted for health insurance.

\$628.28	Gross monthly income
<u>-75.00</u>	WRE deduction
553.28	
<u>-32.00</u>	Health insurance
\$521.28	Net MA income
<u>-350.00</u>	MA standard for 1
171.28	Excess monthly income
<u>x6</u>	
\$1027.68	Six-month spenddown liability

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS (6060)

EXAMPLE 3:

Jill Foley has one child, Eddie, who was hospitalized in February. In April, Jill learns that the health insurance carried by her ex-husband had expired in January when he was fired. She applies for MA on April 20.

Jill earns \$200 per week. In February, however, she worked only one week because of Eddie's illness. She pays \$50 per week for Living and Learning School. This has been verified.

Her spenddown liability is calculated as follows:

For February

For March and Following Month

\$200.00	Total earnings	\$866.66
-75.00	WRE deduction	- 75.00
<u>\$125.00</u>		<u>\$791.66</u>
-40.00	Child care (maximum allowed)	-160.00
<u>\$ 85.00</u>		<u>631.66</u>
-550.00	MA standard for 2	-550.00
		<u>81.66</u>
		x5
		<u>\$408.30</u>

There is no excess income for February. The excess for the following months is multiplied by 5 for a total six-month spenddown of \$408.30

EXAMPLE 4:

Peter Flynn is a recipient of MA/DA. His wife was earning \$205 per week when his case was last redetermined in April. There was no spenddown. Peter's former work had not been covered by Social Security and he has no income. In August Mrs. Flynn receives a raise. Her weekly income is \$232.

\$1006.27	Monthly income
-20.00	SSI disregard/unearned/earned
<u>985.27</u>	
-65.00	
<u>920.87</u>	SSI earned income disregard
-460.10	1/2 of remainder
<u>460.17</u>	Net MA income
442.00	MA standard for 2
<u>18.17</u>	Excess monthly income
x6	
<u>\$ 109.02</u>	Six-month spenddown

A MA/NFL-8R is sent to Mr. Flynn. (6532) The increase in income was reported in August but there is not time to close the case until September 30. The spenddown period is October through March.

6500: THE SPENDDOWN

Eligibility for Medical Assistance is never denied solely because of excess income. In the determination of eligibility, income is the last factor to be considered. When all other requirements are met, the net MA income of the filing unit is compared to the appropriate community or long term care MA income standard. If income is equal to or less than the standard, eligibility is established. If it is greater than the standard, the applicant may become eligible on the basis of spenddown. That is, the deciding factor is the relationship between the excess income and the amount of his medical expenses. If, by assuming responsibility for the difference the applicant "spends down" to the appropriate MA income standard, eligibility is then established.

Medical expenses are applied to the spenddown in two distinct ways: monthly for recipients in long term care facilities (6600) and in six-month periods for residents in the community.

While eligibility for MA is pending (that is while the individual is not entitled to a Medicaid card) bills are counted toward the spenddown at the actual amount billed. This is referred to as the "private rate." Individuals in long term care facilities who have income in excess of the monthly public rate but less than the monthly private rate at the facility must meet the spenddown liability for a six-month period at the private rate.

6510: The Spenddown Period: Community Cases

The spenddown period is a six-month period that begins with the first day of the month of the earliest medical service the applicant wishes to have considered toward his spenddown liability or to have covered by MA. This date may not be earlier than the first day of the third month prior to the month of application, nor may it be later than the first day of the month following the month of application (See 2125). A request for a start date later than this requires that a new application be filed.

EXAMPLE 1:

Thomas Morgan applies for MA/OAA on April 7. He had been hospitalized from January 10 to February 2 and requests retroactive coverage primarily to take care of his Medicare deductible amounts for the year.

Mr. Morgan completes page 8 of the SS-37 showing that he was 65 years old prior to January, that his assets were under \$2000 at that time, and his income was below the MA Income Standard and has not changed.

Since he has established eligibility during the retroactive period, the six-month spenddown period is January 1 through June 30.

EXAMPLE 2:

Theresa Moore applies for MA/21 on April 7. She does not request retroactive coverage. The spenddown period is April 1 through September 30.

EXAMPLE 3:

Ellen Wilson applies for Medicaid on April 7. She was hospitalized from February 26 to March 11. Her 65th birthday was March 6. Page 8 of the SS-37 shows she had not been receiving Social Security Disability benefits and had not been approved by SMRT. The earliest day for which she is eligible is March 1. The six-month spenddown period, therefore, is March 1 through August 31. It is the worker's obligation to inform Mrs. Wilson that she may have her medical records submitted to SMRT if she needs assistance for the last three days of February.

After SMRT approval, if Mrs. Wilson has already met her spenddown on category 05, a second case is opened on category 07 with action reason 03 and a start date of February 26th. As soon as the TD has been accepted on the file, the category 07 case is closed. If the spenddown has not been met on category 05, the February 26 - 28 bill may be applied to the spenddown and there is no need to open a second case.



6521 Spend-down in Adult Foster Care (AFC)

Adult Foster Care is a community-based program, and community standards apply. Regulations governing the responsibility of spouse for spouse (106 CMR 505.450) apply to couples in which one or both are AFC participants. For general information regarding the program, the provider agencies and admission to the program, see 7452 and 2127.

The cost of Adult Foster Care is comprised of three components:

1. Room and Board;
2. Personal Care; and
3. Administrative Costs.

The worker determines the six-month spend-down liability, if any, according to 6520.

Component 1: Room and Board (living expenses) This amount is paid by the AFC participant from his monthly income to his foster care family. Room and Board are not medical expenses, and may not be used to meet a spend-down.

Components 2 and 3 are considered medical expenses and therefore may be applied (along with other medical expenses listed in 6540) toward a spend-down. In SSI cases, Pickle cases, and MA cases having income within the community income standard, components 2 and 3 are billable in their entirety to Medicaid.

The cost of components 1 and 2 which make up the payment to the foster care family are the same throughout the State. The cost of component 3 varies from provider to provider as determined by the Rate Setting Commission.

Since much of the work of the Provider Agency is done prior to the actual placement of the individual in the foster home (e.g. recruiting and training of the family), Program Regulations allow the provider to bill a full month's administrative fee for the first month of placement even though the participant may have been in AFC only a few days. The full monthly administrative cost for each following month is incurred on the first day of the month and may be used immediately toward the spend-down.

For the sake of illustration we will assume that the provider agency, Family Care Corporation of Sleepy Hollow, has a fee of \$23.80 per day and that payment is divided as follows:

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\$7.50 Room and Board provided by foster family  
\$7.50 Personal Care by foster family  
\$8.80 Administrative Costs

From his monthly income the AFC participant pays his foster family directly for his room and board (\$225 for a 30-day month or \$232.50 for a 31-day month.) The remainder is for his own individual expenses. There is no "personal needs allowance" in a community case, and the amount of money remaining after payment for food and shelter differs from individual to individual.

Mrs. Graham is a recipient of MA/OAA living in an adult foster home under contract with the Family Care Corporation of Sleepy Hollow. Her only income is her \$400 Social Security benefit. Eligibility is determined as follows:

\$400.00	Monthly Income
<u>-20.00</u>	SSI-Related Disregard
380.00	Net MA Income
<u>-350.00</u>	Community Standard for 1
30.00	Excess Monthly Income
<u>x6</u>	
\$180.00	Six-Month Spenddown

Mrs. Graham receives her Social Security check on April 3 and pays her foster family \$225 for her room and board.

Sleepy Hollow bills Mrs. Graham \$489 for April. (\$225 for personal care and \$264 for the administrative costs). She submits this bill to the eligibility worker.

Sleepy Hollow bills Medicaid \$207 for April.

\$489.00	Total Bill
180.00	Participant's Liability
309.00	Amount Billed Medicaid

The worker notifies Mrs. Graham of her eligibility with a copy to the Medicaid Division (address in 2127) and completes the T.D. to enter the case on the Recipient Master File. The spenddown period is April through September. In each of the remaining five months (May through September) Sleepy Hollow bills Medicaid for the entire amount of components 2 and 3.

Coding the T.D.

The T.D. should be coded as any other community case with the address that of the foster home.

The Social Security Administration has designated Group B (Shared Living Arrangements) as the budget group for SSI recipients living in an adult foster care setting. For consistency, therefore, Block 23 should be coded "2A". The 6-month spenddown (\$180 in the case illustrated above) is placed in Block 26 and a "1" in Block 27 indicating six-month spenddown for community case). The medical start date is April 1.

6530: Notification of Potential Eligibility (Spenddown)6531: Applicant

An applicant who would be eligible for Medical Assistance except for excess income is sent an MA/NFL-8A (Notification of Spenddown Liability). In effect he is told that he is ineligible at the present time, but he may become eligible if during the six months of the spenddown period, allowable medical bills (after insurance) that equal or exceed his excess income for the period are incurred.

The MA/NFL-8A contains the following information:

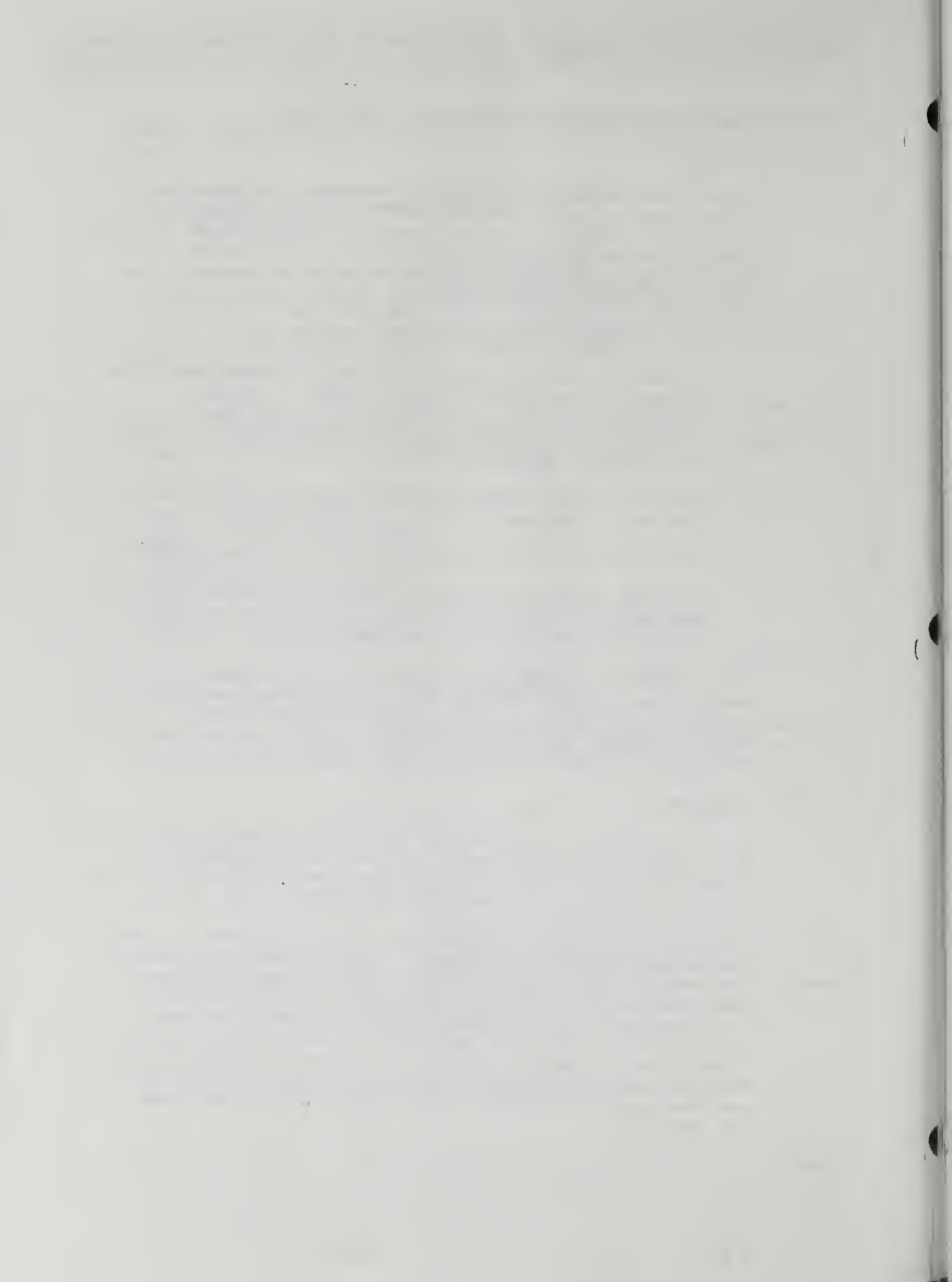
- A. the amount in medical expenses for which the applicant is responsible before Medicaid can participate in payment;
- B. a reference to an attached copy of the calculations by which this figure was determined;
- C. the dates of the six-month period during which these medical services may be received;
- D. the procedure for submitting medical bills for consideration;
- E. a reminder of the obligation to report all changes in his circumstances that might affect his eligibility or necessitate an adjustment in the amount of the spenddown.

If the applicant brings in bills meeting the spenddown in the fifth month of the spenddown period, for example, he does not file a new application unless he wishes to change the start of his six-month spenddown period. Any change in income during the spenddown period necessitates a recalculation of the spenddown amount.

6532: Recipient

A recipient whose eligibility has been redetermined and whose income is in excess of the MA standard must be informed by means of an MA/NFL-8R that his eligibility is being terminated but that he may re-establish eligibility by meeting a spenddown.

The MA/NFL-8R lets the recipient know that there will be a break in the continuity of his assistance. This could make a difference in the order in which the individual or family schedules medical appointments (i.e., dental appointments for those not in the assistance unit prior to appointments for those in the unit, etc.) In the case of Peter Flynn above (6520: Example 5), since Mrs. Flynn's medical expenses can be used to meet the spenddown, she would be wise to schedule for October any medical appointments she may have been putting off. In this way Peter's spenddown will be met earlier.





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## 6540: Submission of Medical Bills to Meet Spenddown

6540

Bills used to meet the spenddown liability may be either paid or unpaid, but they must be for services rendered within the six month spenddown period. All bills submitted for application toward the spenddown are to be reviewed in the following manner.

- A. Check the date. Be sure the date being considered is the date of service, not the date of billing. (The same service may result in several billings before payment is made.)
- B. Check the name of the person who received the service. Is he a member of the filing unit? (That is, were his income and assets included in the most recent determination of eligibility?)
- C. Be sure the necessary provider information appears on the bill i.e. type of provider as well as name and address. If you know the provider's Medicaid billing number, include it.
- D. Check the application or redetermination form and TPL Supplement for health insurance coverage. If there is health insurance, has payment been made or notice of disapproval received? The bill must show the total charge for the service as well as the balance after the insurance payment. Only the balance due after the insurance payment may be applied to the spenddown.
- E. Be sure the service is one that is covered by the Medical Assistance Program (7470) or specifically allowed for spenddown purposes. Examples of non-MA services that may be counted:
  - . health insurance premiums;
  - . non-prescription drugs;
  - . disposable diapers for an incontinent adult; and
  - . air-conditioners, humidifiers or other health related equipment when prescribed by a physician.

Workers are often requested to consider a wide variety of bills toward the spenddown obligation that are not actually medical in nature. Some, but by no means all, of the frequently submitted bills that may not be credited toward the spenddown are:

- . cosmetic surgery;
- . rest home care (this is primarily room and board - not a medical expense);
- . weight training equipment;
- . masseur(euse) services; and
- . special diets



If the bill is not legible, or there is any other problem with the bill, contact the applicant informing him of the problem. It is the applicant's responsibility to obtain a corrected bill.

When the bills have been reviewed and found to meet all the specifications of A. through E. above, copies are filed in the case record as verification. Bills for nonprescription drugs are verified by a receipt from the provider of the drug. Note that after a quarterly \$25.00 deductible, Medex Standard and Medex III pay for 100% of generic drugs and 80% of brand name drugs.

6541: Prioritization of Medical Bills Used to Meet Spenddown

In some cases one bill may be all that is necessary to meet the spenddown. If several are needed to meet the liability, however, there is a definite order in which they must be counted.

- A. Premium payments for health insurance or fees for pre-paid health maintenance plans. (Premiums for indemnity insurance policies may not be used to meet the spenddown).
  1. If health care coverage is deducted from income received, it is allowed as a general deduction except in SSI-Related community cases (6130); if it is paid directly by the MA applicant/recipient to the insurer, it is applied toward the spenddown.
  2. Health care coverage is the only medical expense that may be allowed prospectively. That is, credit may be given for the cost of six-months' coverage by virtue of verification of payment of the current premium. (A Medex payment for three months is multiplied by two).
- B. Bills for services to members of the filing unit who are not eligible as members of the assistance unit (e.g. parents over the age of 21 in an MA/21 case, or responsible spouse of an SSI-related applicant). Be sure to count only the portion of the bill remaining after third party payment.
- C. Bills for non-Medicaid services allowed per 6540 E.
- D. Bills, other than health insurance premiums, from providers who do not participate in Medicaid and do not have a Medicaid billing number.
- E. Bills already paid for services to eligible members of the assistance unit.
- F. Unpaid bills for eligible members of the assistance unit that may be paid by Medicaid once the spenddown is met.

6542: Recording of Bills Used to Meet Spenddown

Bills submitted by an applicant to meet his spenddown liability must be recorded on a Surplus Income Data Form, PA-37 (Rev. 4/87). This form contains the instructions necessary for workers to complete it.

6543: Split Bills

Since split bills must be processed manually and necessitate extra work for both the Department and providers, they should be avoided if the spenddown can be met in any other way without penalizing the recipient. Bills from most provider types can be broken out into separate bills for different dates of service or specific identifiable services.

When an applicant in spenddown status receives a hospital bill which, even after the application of any third-party coverage, exceeds the amount of his spenddown liability, this situation requires communication between the worker and the hospital billing office to determine that portion of the spenddown to be applied to the hospital bill. The worker must be careful not to exclude the applicant from any decision about how his spenddown is to be met.

All bills that cannot be paid by Medicaid must be listed first on the Surplus Income Data Sheet (PA-37) so that the applicant is aware of his "outstanding balance". If there are other immediate medical needs that will not be covered by Medicaid even after eligibility has been established, (e.g., a dental appointment scheduled for an ineligible member of the filing unit), these may be applied toward the spenddown before the hospital is informed of the unmet balance. It is also necessary that the applicant be involved at this point so that the worker may review the eligibility factors and make any necessary adjustments to the spenddown amount. (See 6547.)

Once the worker and the applicant have determined the balance of the spenddown for the filing unit, the worker informs the hospital of this amount. The hospital will send the worker a copy of the UB-82 for the total charges or a UB-82 interim bill with total charges that exceed the spenddown amount. (This is done only when the patient is still in the hospital). The amount shown on the UB-82 will be at the hospital's private rate and must show any payment made from a third party. The amount remaining will become the last entry on the PA-37. Make sure that the spenddown amount is the amount agreed upon with the applicant. Notify the hospital if it is not. The hospital will then submit the original of the UB-82 to SDC.



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## 6544: Two Assistance Units in Family

John Peters receives a Social Security Disability benefit of \$350 per month and as a kidney dialysis patient is covered by Medicare. His wife, Sara, works three evenings per week, earning \$30 each evening. They have one child, Nancy, still at home. There is no health insurance coverage for Sara and Nancy.

In March, Nancy incurs a \$325 outpatient hospital bill, and the family applies for Medicaid.

Applying for MA/AFDC for the whole family, eligibility is determined as follows:

Sara's Monthly Income	\$ 390	(13 x \$30)
	- 75	Work Related Expenses
	<u>315</u>	Sara's Net Countable Income
John's Monthly Income	+ 350	(No Disregards)
	<u>\$ 665</u>	Total MA Income
	- 497	MA Standard for 3
	<u>168</u>	Excess Monthly Income
	x 6	
	<u>\$1008</u>	Six-Month Spenddown for a filing unit of 3 and an assistance unit of 3.

The family may apply as two separate assistance units.

Applying for MA/DA for John, eligibility is determined in the following manner:

John's Monthly Income	\$ 350	
	- 20	(SSI-Related Disregard-Unearned Income)
	<u>\$ 330</u>	John's Net Countable Income
Sara's Monthly Income	\$ 390	
	- 65	(SSI-Related Disregard-Earned Income)
	<u>325</u>	
	- 167.50	" " " "
	<u>\$ 167.50</u>	Sara's Net Countable Income
	+ 330.00	
	<u>\$ 497.50</u>	Total Countable Monthly Income
	- 442.00	MA Standard for 2
	<u>55.50</u>	Excess Monthly Income
	x 6	
	<u>\$ 333.00</u>	Six-Month Spenddown for a filing unit of 2 and an assistance unit of 1

Sara may apply for MA/AFDC for herself and Nancy. Eligibility would be determined in exactly the same way as above for the entire family. John would be included in the filing unit but not in the assistance unit.



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

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John and Sara are mutually responsible for each other, and their income must be counted in whatever assistance unit is selected. If this means counting their income twice, then their medical bills may be counted twice. Nancy is not responsible for her parents, and her income, if she had any, would not be counted in the MA/DA filing unit. Her bills, therefore, cannot be counted in the MA/DA filing unit.

At the time of their application, the family has the following medical expenses:

John	\$ 150	Transportation to Dialysis for March
Sara	125	Yearly physical exam - March 3
	17	Prescription
	35	Dental bill - March 10
Nancy	325	Hospital bill - March 24

The bills are applied against each filing unit.

AFDC-Related	\$ 125	chronologically, since <u>all</u> are included
	17	
	35	
	325	
	150	
	<u>\$ 652</u>	against a total spenddown of \$1008

---

SSI-Related	125	Sara's bills are counted first since she is
	17	not categorically eligible
	35	
	150	
	<u>\$ 327</u>	against a total spenddown of \$333

---

John will meet his spenddown when he or Sara incurs a medical expense of \$6.00 or more. The spenddown for Nancy and Sara is exactly the same as it would be if John were included in the assistance unit, since he must be included in the filing unit. The MA/AFDC case for Nancy and Sara, therefore, will remain in spenddown status after John's case is approved and entered on the system.

Any additional bills incurred by John that are not covered by Medicare or Medicaid but are allowed for spenddown purposes may be applied to the MA/AFDC filing unit's spenddown for the six-month period.



6545: Bills in Excess of Public Rate Used to Meet Spenddown

In some instances the applicant's spenddown liability is less than the private rate charged by a provider but more than the public (Medicaid) rate.

In such a case, the spenddown is met by this bill. No additional payment is made by the Department to the provider; therefore whether or not the provider will reduce his bill is a matter strictly between the provider and the patient. The bill should be sent, along with the PA-37 (Rev. 4/87) showing the spenddown liability, to the address on the PA-37 to prevent payment by Medicaid of a bill already used to meet the spenddown.

6546: Submitted Bills Do Not Meet Spenddown

If all submitted bills that can be allowed toward the spenddown liability are less than the spenddown amount, the worker informs the applicant of the spenddown balance by giving him a copy of the PA-37 as it stands to date. If bills were submitted that cannot be allowed, they should be listed in a letter or memo to the applicant in some manner such as:

1/7/84 Dr. Baker - prior to budget period  
2/2/84 Dr. Feinman - Jenny is over 21 - no longer eligible  
2/6/84 Dr. Somers - cosmetic surgery not an allowable expense

6547: Review of Eligibility Requirements at Time Spenddown is Met

When medical bills are submitted that meet the spenddown liability, other eligibility factors are reviewed. Any changes in income or standards require a new computation of the spenddown liability.

- A. Is the composition of the filing unit still the same?
- B. Is the composition of the assistance unit still the same? Check age.
- C. If there is earned income, has there been any change? Verify latest pay stub.
- D. If the applicant was unemployed at the time of original application, is he still unemployed? Verify latest U.C. check.
- E. Is parent still incapacitated?
- F. Is parent still absent?
- G. Have any potential benefits previously applied for been received?
- H. Have Department regulations or income standards changed?

6548: Conclusion of Spenddown Process

When bills submitted equal or exceed the spenddown liability, and all other eligibility requirements continue to be met, eligibility is established.

The applicant is sent the spenddown acceptance letter (MA/NFL3SP) and a copy of the PA-37 listing the bills for which he is responsible. He is informed that he is eligible for payment of all MA covered services during the spenddown period other than those counted toward the spend-down.

6549: Coding the Turnaround Document

When entering a spenddown case on the Recipient Master File the worker enters:

- A. Block 1 - the date on which the last bill needed to meet the spend-down is received in the local office;
- B. Block 17 - the date of the beginning of the six-month spenddown period;
- C. Block 18 - the date of application;
- D. Block 26 - the \$ amount of the six-month spenddown;
- E. Block 27 - "1" denoting 6-month spenddown. MA/ID cards will be terminated automatically six months after the date in block 17. No MA-ID cards will be issued until the case is reopened.

6550: Meeting the Spenddown Retroactively

An applicant or recipient might not receive all the medical bills he or she incurred during his or her spenddown period until after the six month period has ended. When all the bills are in, the individual or family often has incurred enough bills to meet the spenddown.

If the individual or family is not currently eligible, you can put the case on the system retroactively for the six-month spenddown period, using the begin date of the eligibility period as the opening date, and the opening Action Reason code 03. This transaction will cause this case to appear on MMIS, so that bills can be paid, but no MassHealth card will be issued because the case will not be put on the MassREVS system.

Send the Notice of Approval for Medicaid, MA/NFL-3SP, granting eligibility for a finite period. Cross out the paragraph that refers to the MassHealth card. Issue a temporary Medicaid card for the entire spend-down period.

The following day submit a TD to the data entry operator. This TD should close the case with the AR 69 effective the last day of their six-month eligibility period.

It is not necessary to send a closing notice, as the applicant or recipient has been informed of their finite eligibility period on the MA/NFL-3SP. Send a redetermination to determine prospective eligibility.



6580: Redetermination of Spenddown Cases

Although the MA-ID card is suppressed by the computer at the end of the six month spenddown period, each office should keep track of when spenddown cases are due for redetermination by means of a tickler file since they are a major area of potential QC errors. Spenddown cases are the first priority on the FOR-2 report but this is not always issued early enough to allow 30 days for the return of the form and another 10 days for notification of termination.

When an active spenddown case reaches the fifth month of the spenddown period, the worker sends the recipient a redetermination form. If the redetermination form is not returned within 30 days, the case is terminated using an NFL-1. (See 2215)

If the completed redetermination form is returned, and all eligibility requirements other than income are met, an MA/NFL-8R is sent. The summary of evidence on the MA/NFL-8R reads "You and/or your family have income greater than the amounts allowed in the Medical Assistance Policy Manual (106 CMR 506.410/506.520 for community cases, 106 CMR 506.420/506.620 for long term care cases). This letter explains how the spenddown amount was determined and notifies the recipient of the procedures for submitting bills to meet the spenddown.

The effective date of termination on the MA/NFL-8R and the closing date on the T.D. should be the last day of the month of the closed-end six-month eligibility period except in RRP cases. (See 4844).

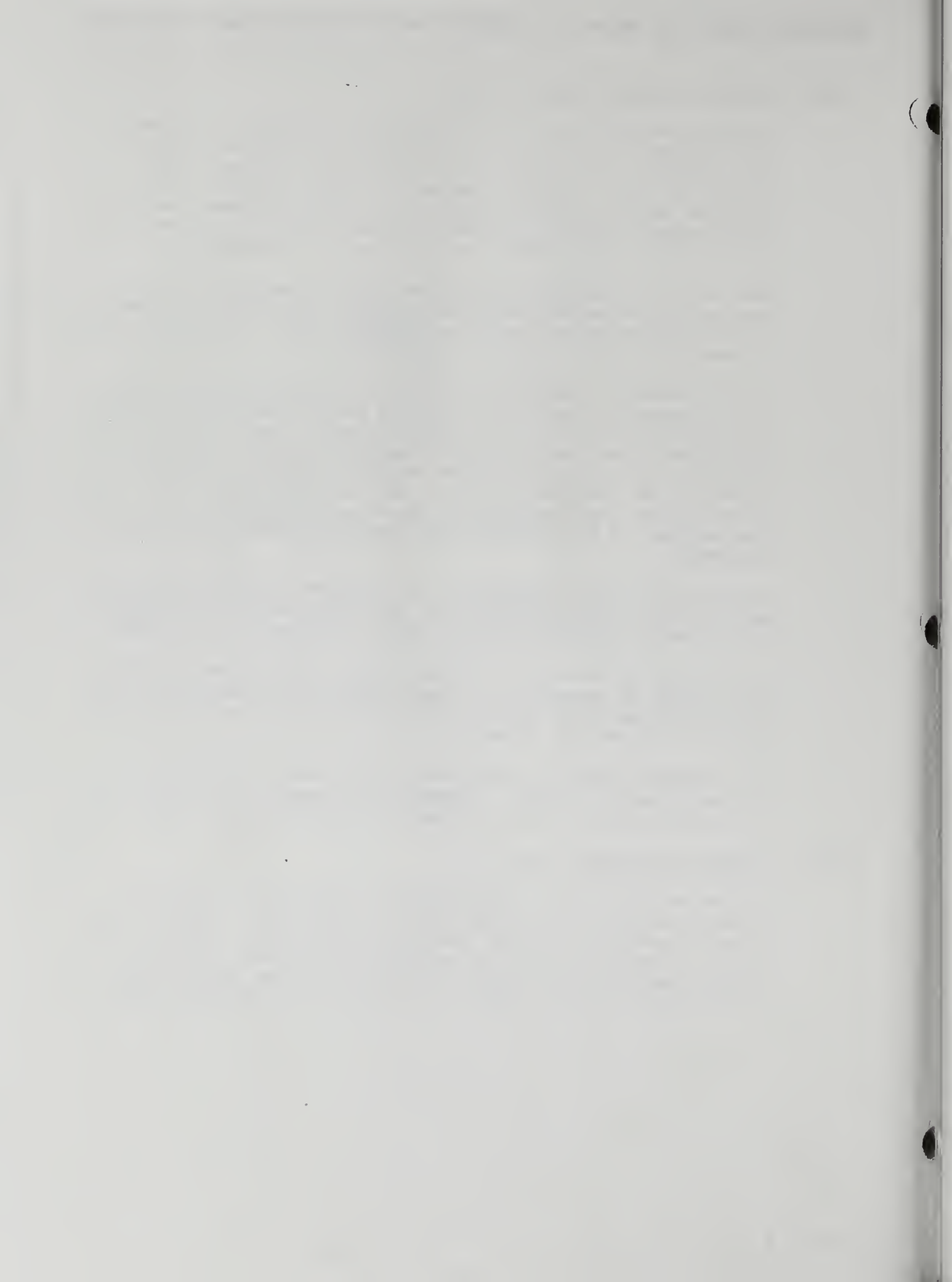
The date to be entered on the MA/NFL-8R as a cut-off for receipt at the Division of Hearings of a timely appeal is the date on the Case Closing and Reduction Schedule (2521). The notice must be sent 10 days prior to the cut-off date.

If redetermination shows that there is no longer excess income, the case remains eligible. Zeroes must be entered in blocks 26 and 27 so that the recipient will receive an MA-ID card each month.

6581: Appeals on Spenddown Cases

If the recipient files a timely appeal, assistance is continued through the end of the calendar month in which a fair hearing decision is rendered. The case remains open on the RMF. However, the code 1 in block 27 causes the suppression of the MA-ID card six months from the date in block 17. For this reason, an ID-2 card is issued manually until an appeal decision has been rendered (2331).





6600: SPEND-DOWN ELIGIBILITY: LONG-TERM-CARE CASES

Residents of long-term-care facilities (nursing homes, intermediate care facilities, chronic hospitals), are permitted to become eligible for MA by "spending-down" their excess income monthly rather than having to incur the total six-month spend-down prior to eligibility for the first Medicaid payment in their behalf.

Federal regulations permit the use of the one month spend-down only for institutionalized residents of long-term-care. In order for any other Medicaid reimbursable program to use a one-month spend-down, a waiver must have been granted by H.C.F.A. (Such a waiver is usually good for only two years and at present only the hospice program has such a waiver.) Any other so-called "alternatives to long-term-care" that may have inadvertently been approved for a one-month spend-down should be converted to the six-month spend-down.

6610: Calculating the Spend-Down Liability

The spend-down liability is determined by subtracting the MA income standard for long-term-care (personal needs allowance) from the Net MA Income (that is, the total income minus the applicable earned income and general deductions). If the excess monthly income is less than the cost of care at the public rate for the facility, the individual meets his spend-down liability by paying his excess income to the facility monthly toward the cost of his care. This is the "patient paid amount" or "one-month spend-down".

Section 6200 of this chapter provides examples of calculating the patient paid amount in cases where there are allowable deductions for

earned income	6211
health insurance	6221
maintenance of home	6222
support of eligible dependents	6223

Sections 5410 and 5450-54 provide examples of the spouse or parent's responsibility for the individual in long-term care.

Following is an example illustrating the spend-down when both members of a couple are in a long-term-care facility.

EXAMPLE:

Carl and Clara Jordan share a room in Knickerbocker Nursing Home. Carl receives \$450 Social Security and \$560 from a private pension. Clara receives \$225 Social Security. They are mutually responsible for each other.

\$450	Social Security - Carl
560	Pension - Carl
225	Social Security - Clara
<u>\$1235</u>	Total Income
-80	LTC Income Standard for 2
<u>\$1155</u>	Patient Paid Amount for 2

\$575.50 Patient Paid Amount Each

If Carl were on a different level of care from his wife and they were not able to be in the same room, the patient paid amount would be determined separately.

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(6060)

<u>Carl</u>		<u>Clara</u>	
\$450.00	Social Security	\$225.00	
<u>560.00</u>	Pension	<u>-45.00</u>	
\$1010.00	Total Income	\$180.00	P.P.A. for Clara
<u>-45.00</u>			
\$965.00	P.P.A. for Carl		





6620: Spenddown Liability in Excess of Cost of Care (Over/Unders)

Some patients in long-term-care facilities have monthly income in excess of the cost of their care at the public (Medicaid) rate but not great enough to be able to pay the private rate. These are referred to as "OVER-UNDER" cases.

If the monthly income after the deductions allowed in 6210 and 6220 exceeds the MA standard for long-term-care (that is the personal needs allowance) by more than the monthly cost of care at the public rate, the six-month spenddown is applied.

The applicant is a private patient until he incurs allowable medical expenses equal to his excess monthly income multiplied by six. When the spenddown liability is met, the Department pays the cost of care for the remainder of the six-month period. There is no patient paid amount because this has already been paid "up front". (In order for the L.T.C. facility to be paid, block 27 may be coded "7" for the remainder of the spenddown period.)

EXAMPLE 1:

The private rate charged to patients at Lakeshore Nursing Home is \$48 per day. the MA rate is \$33.60. Mrs. Stevens' monthly income is \$1,200. She applies for MA in January.

<u>Private Rate</u>		<u>Public Rate</u>	
30-day mo.	31-day mo.	30-day mo.	31-day mo.
\$48.00	\$33.60	\$33.60	\$33.60
x30	x31	x30	x31
1,440.00	\$1,488.00	\$1,008.00	\$1,041.60

Mrs. Stevens does not have enough income to pay the private rate but has more than the public rate plus a personal needs allowance. Her case is established as a six-month spenddown case with a standard of need of \$45. The closed-end six-month spenddown period is January through June.

\$1200.00	Total Monthly Income
-45.00	(P.N.A. (MA Income Standard for L.T.C.))
\$1155.00	Excess Monthly Income
x6	
\$6930.00	Six-Month Spenddown

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6620-2

Mrs. Stevens meets her spenddown liability as follows:

<u>January</u>	Lakeshore N.H.	\$1,488.00	(31 days @ 48)
	Corner Pharmacy	44.20	
	Dr. Foote (Podiatrist)	20.00	
<u>February</u>	Lakeshore N.H.	1,344.00	(28 days @ 48)
	Corner Pharmacy	39.60	
<u>March</u>	Lakeshore N.H.	1,488.00	(31 days @ 48)
	Corner Pharmacy	55.90	
	Dr. Blake (G.P.)	25.00	
<u>April</u>	Lakeshore N.H.	1,440.00	(30 days @ 48)
	Corner Pharmacy	41.00	
		<u>5,985.70</u>	
	Total Spenddown	6,950.00	
	Expenses thru April	<u>5,985.70</u>	
		944.30	remaining spenddown

The \$944 is divided by \$48 to determine the number of days for which Mrs. Stevens is responsible in May. (19 days at \$48)

May 1 through 20	\$ <u>912.00</u>
	32

Mrs. Stevens assumes responsibility for \$14.32 of her pharmacy bill for May, and is eligible for MA from May 20 through June 30 with no further payments.

## EXAMPLE 2:

Mr. Farnsworth has been a patient at Lakeshore for three years. His income is \$1400 per month. He has been supplementing this from his savings in order to pay the nursing home bill. His wife, who is 68, is dependent on him for part of his income since her Social Security is only \$236 per month. Their savings are now down to less than \$3000 and Mr. Farnsworth applies for MA in March. The couple pays \$129.44 each quarter for Medex for both of them.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6620-3

EXAMPLES SHOW METHOD OF CALCULATION - SEE CURRENT INCOME STANDARDS  
(6060)

## Mrs. Farnsworth

Total Income	\$236.00
SSI Disregard	-20.00
	<u>\$216.00</u>
MA Income Standard	\$350.00
Net MA Income	-216.00
Income Need	<u>\$134.00</u>

## Mrs. Farnsworth

Income	\$1,400
Eligible Dependent	-134
	<u>\$1,266</u>
MA Income	\$1,266
MA Standard	-45
	<u>\$1,221</u>
Excess Income	\$1,221
Six-month Spenddown	x6
	<u>\$7,326</u>

The closed-end spenddown period is March through August. Mr. Farnsworth meets his spenddown as follows:

6 months Medex premiums for each member of couple	
4 x \$64.74	\$258.96
(March) Lakeshore N.H.	1,488.00
Corner Pharmacy	32.00
Dr. Jones (Ear Specialist)	35.00
Dr. Foote	20.00
(April) Lakeshore N.H.	1,440.00
Corner Pharmacy	47.60
Bell Tone (Hearing Aid)	450.00
(May) Lakeshore N.H.	1,488.00
Corner Pharmacy	37.40
Dr. Blake	25.00
(June) Lakeshore N.H.	1,440.00
Corner Pharmacy	36.00
Dr. Foote	20.00
	<u>\$6,817.96</u>
Total Spenddown	6,980.00
March through June	6,817.96
	<u>111.04</u>
	-96.00
	<u>15.04</u>

Mr. Farnsworth is responsible for 12 days in July plus 15.00 of his July pharmacy bill. He is eligible for MA from July 14 through August 31.

Provider regulations call for a signed agreement between the recipient and the facility whereby the recipient agrees to resume payments as a private patient at the end of each six-month spenddown period. This precludes and appeal whereby the recipient could continue with no patient paid amount.



6630: Notification of Eligibility

The applicant or recipient as well as the long-term care facility is notified of the amount of the monthly spend-down liability (Patient Paid Amount) by means of a PI-1 form. This actually corresponds to the MA/NFL-8 for community spend-down cases. It includes the method of calculation by which the PPA was determined and is sent to both the recipient and the facility at the time of each redetermination and each change in monthly income.

PI-1 forms are used for all Intermediate Care Facilities (ICF's), all Skilled Nursing Facilities (SNF's), all chronic hospitals, all rehabilitation hospitals, and all public mental hospitals. Following is a list of facilities other than nursing homes for which PI-1's are needed.

Listing of Chronic Hospitals Participating in MA

PI-1's are necessary for recipients in these institutions.

<u>Vendor #</u>	<u>Name</u>
1100025	Barnstable County Hospital
1100033	Beaconcrest Chronic Disease Hospital
1100777	Boston State Hospital
1100882	Braintree Hospital
1100211	Christian Science Benev. Assoc.
1100149	City of Salem, Dr. Robert Shaughnessy CD/Rehab.
7101171	Connecticut Valley Hospital
1100076	Cushing Hospital
1100807	Danvers State Hospital
1100084	Frances P. Memorial Hospital
110106	Grover Manor Hospital
1100122	Hampshire County Chronic Disease
1100769	Harry C. Solomon Mental Health Center
1100408	Hebrew Rehabilitation Center for Aged



6630 (cont')

<u>Vendor #</u>	<u>Name</u>
1100157	Jewish Memorial Hospital
1100939	Kennedy Memorial Hospital
1100653	Lakeville Hospital
1100513	Lemuel Shattuck Hospital
1101226	Long Island Hospital
1100742	Massachusetts Mental Health Center
1100203	Massachusetts Rehabilitation Hospital
1103652	Mattapan Chronic Disease Hospital
1100823	Medfield State Hospital
1100602	Medical Center Western, MA
1100793	Metropolitan State Hospital
1199951	Middlesex County Hospital
1100556	Milford Whitinsville Regional
1100661	Mount Pleasant Hospital
1100483	New England Rehabilitation Hospital
1100718	New England Sinai Hospital
1100246	Newburyport Manor Chronic Disease
1100254	Norfolk County Hospital
1100866	Northampton State Hospital
1102788	Notre Dame Norml. Inst.
1199773	Otis Hospital
1100262	Pentucket Manor Chronic Disease Hospital
1199943	Plymouth County Hospital

## MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

6630 (cont.)

6630

<u>Vendor #</u>	<u>Name</u>
1100602	Medical Center Western, MA
1100793	Metropolitan State Hospital
1199951	Middlesex County Hospital
1100556	Milford Whitinsville Regional
1100661	Mount Pleasant Hospital
1100483	New England Rehabilitation Hospital
1100718	New England Sinai Hospital
1100246	Newburyport Manor Chronic Disease
1100254	Norfolk County Hospital
1100866	Northampton State Hospital
1102788	Notre Dame Norml. Inst.
1199773	Otis Hospital
1100262	Pentucket Manor Chronic Disease Hospital
1199943	Plymouth County Hospital
1100785	Rutland Hts. Hospital
1100289	Springfield Municipal Hospital
1100297	St. Camillus Hospital
1199935	St. John of God Hospital
1101269	Tewksbury Hospital
1100475	University Hospital Extended Care Unit
1100947	Washingtonian Cent. for Addictions
1100491	Westborough State Hospital
1100432	Western Massachusetts Hospital
1199706	Worcester County Hospital

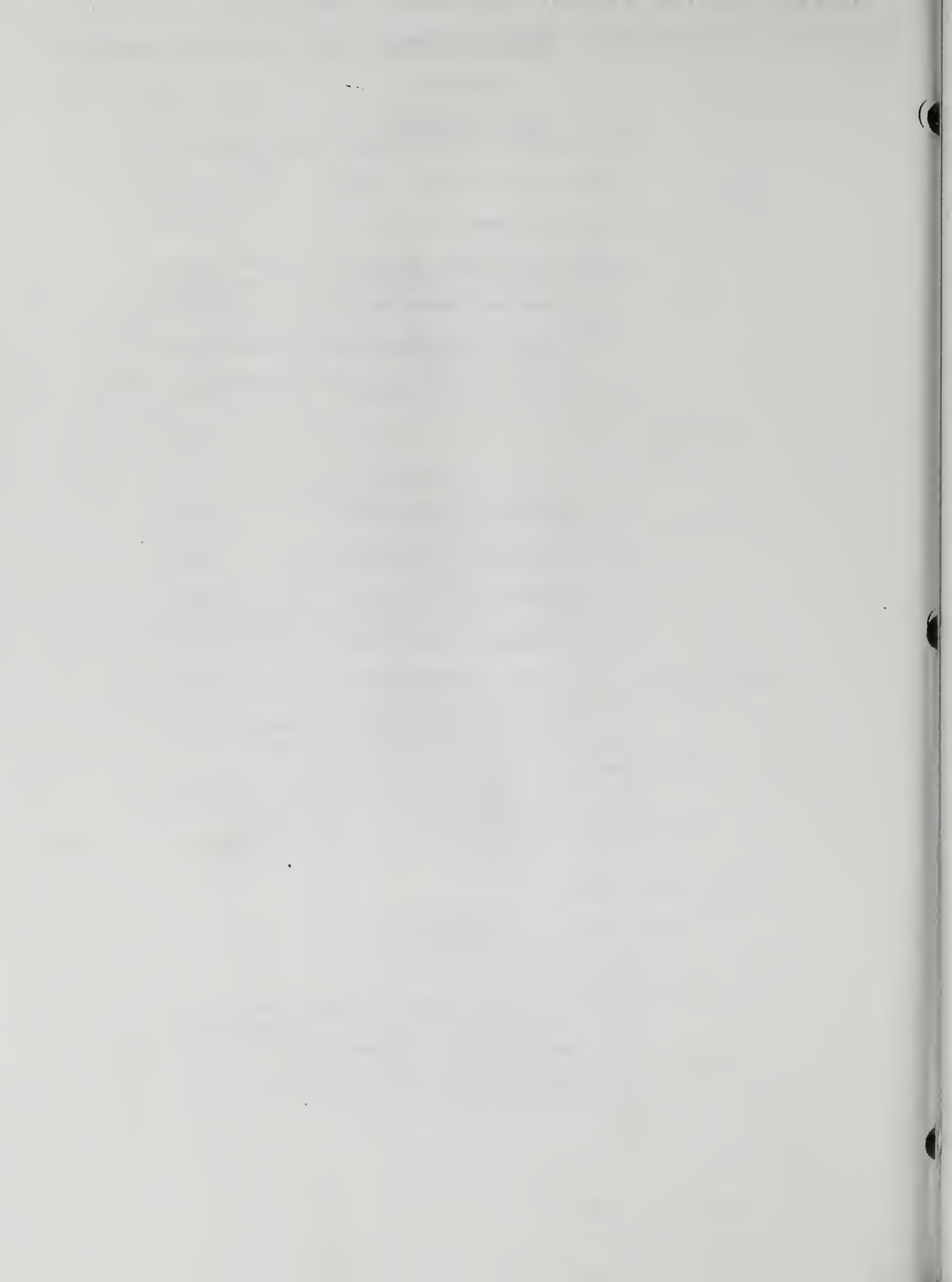
6630 (con't)

Listing of Chronic Hospitals Participating in MA

<u>Vendor #</u>	<u>Name</u>
1100785	Rutland Hts. Hospital
1100289	Springfield Municipal Hospital
1100297	St. Camillus Hospital
1199935	St. John of God Hospital
1101269	Tewksbury Hospital
1100475	University Hospital Extended Care Unit
1100947	Washingtonian Cent. for Addictions
1100491	Westborough State Hospital
1100432	Western Massachusetts Hospital
1199706	Worcester County Hospital
1100874	Worcester State Hospital
1100343	Youville Rehabilitation and Chronic Disease
1100831	Taunton State Hospital

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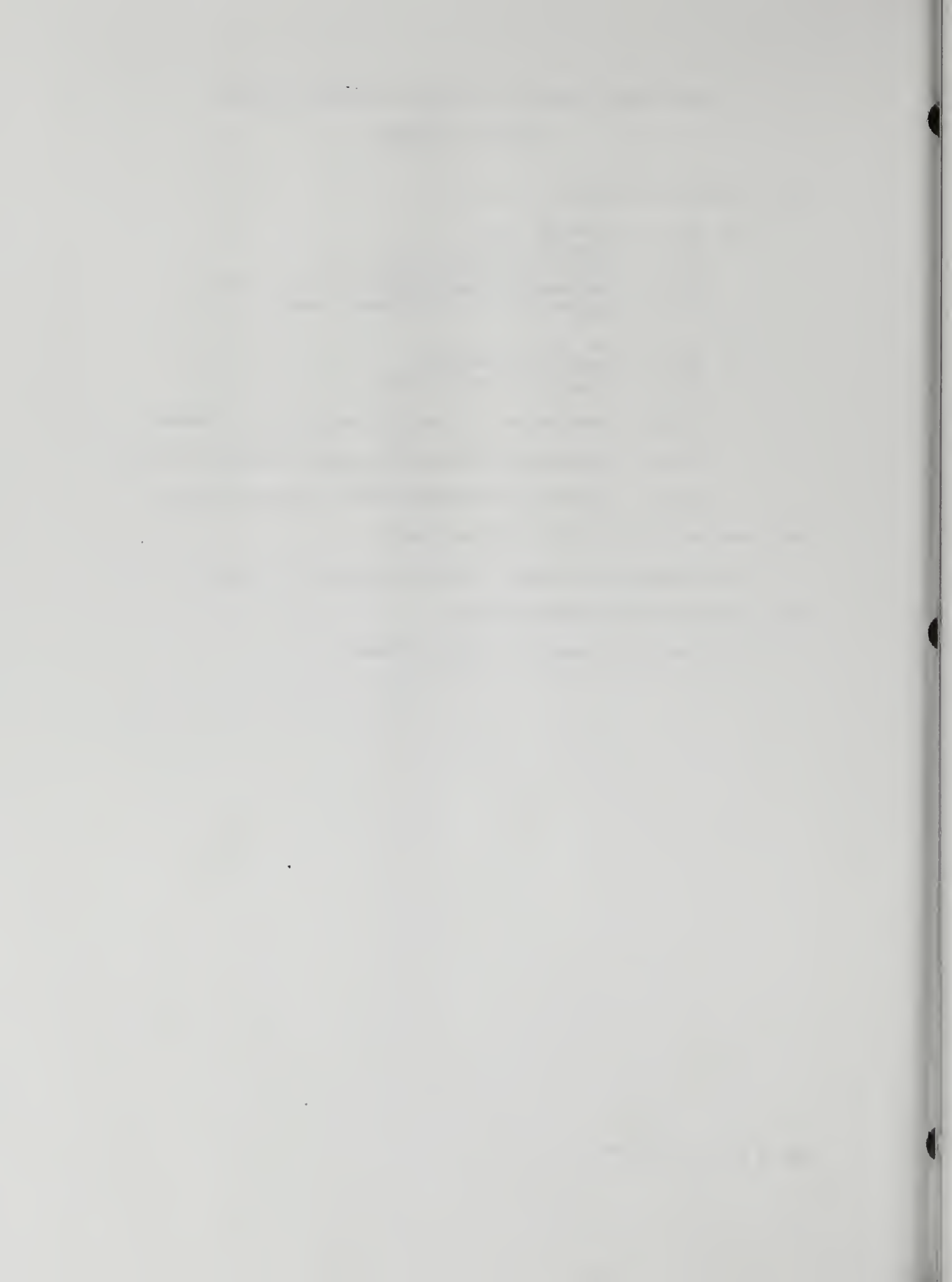
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7100: FUNERAL AND BURIAL EXPENSES

Funeral and burial expenses are authorized when necessary by the Commonwealth of Massachusetts as a special benefit to recipients of all cash assistance programs and to recipients of the Medical Assistance Program. If a deceased recipient of Medical Assistance was also a recipient of one of the cash assistance programs, payment for funeral and burial expenses is made by the appropriate cash assistance program.

If the deceased recipient of Medical Assistance was also a recipient of SSI payment will be made under the Medical Assistance Program. Special requirements for determining eligibility and for making payment for MA and SSI recipients are noted in following sections.

For cases in which an application is made on behalf of a deceased person, eligibility for funeral and burial expenses is determined in the same manner as for a recipient, provided eligibility for Medical Assistance has been established.

7110: Limitation on Funeral and Burial Expenses

The Department provides payment of up to \$300.00 for funeral and/or burial expenses when existing resources are insufficient to meet this need (see 7120).

For recipients of Medical Assistance only (categories 05-08) funeral/burial expenses may not exceed \$500.00.

For recipients of SSI (categories 01 and 03) expenses may not exceed \$900.00.

When a worker receives a request for payment of funeral and/or burial expenses, he must request verification of the amount. Acceptable verification is an itemized bill and signed statement by the funeral director indicating the total cost of the funeral and burial. If expenses exceed the above amounts, the worker denies the request for benefits. If expenses are within limitations, the worker assesses all resources available to the deceased.

7120: Exploration of Available and Potential Resources

The Department may not require that assets be disposed of or that funds be applied to funeral or burial expenses. However, if funds are readily available and are not applied to expenses, eligibility for assistance is denied.

The assessment of available resources includes a review of the information in the case record. Questions the worker might consider are the following.

- A. Bank account or PNA account. Did the recipient have funds in a bank account or PNA? If so, what has happened to these funds?
- B. Securities. Did the recipient possess securities, stocks, bonds, or notes? If so, what was the disposition of these assets?
- C. Life insurance policies.
  - 1. Did the recipient own life insurance policies?
  - 2. Who is the beneficiary of the policy?
  - 3. Will benefits be paid by the insuring company? If so, when, to whom, and how much will the insurance company pay?
- D. Prepaid burial contract or cemetery lot. Did the recipient own a prepaid burial contract or cemetery lot? Has the contract or lot been used?
- E. Automobile. Did the recipient own an automobile or recreational vehicle? What was the value of this asset and how will it be disposed of?
- F. Home or real estate. Did the recipient own his home or other real estate? What was the value of this property and what will its disposition be?
- G. Income. Did the recipient have regular income, such as investment income, or income from real estate, that may be owed to the estate? What has become of payable income? Was the recipient employed? Are any retirement or death benefits payable?
- H. Contributions from friends or relatives. Are friends or relatives willing and able to contribute to funeral and burial expenses? If so, how much?
- I. Veterans Administration (VA) Funeral Payment (up to \$300.) This payment is only available for a veteran who at the time of death was receiving or was eligible to receive a VA pension or a service related disability compensation (Veteran's dependents are not eligible). An amount not exceeding \$150.00 may be paid for

7120

any veteran, as a plot or interment allowance when the veteran is not buried in a national cemetery. (If the death was service connected or if the veteran had been receiving 100% disability payments, a higher burial allowance may be available.)

The claim may be filed with any VA office within 2 years of the cremation or burial,

However burial or plot allowances will not be provided to the extent that they were paid by the deceased veteran's employer or by a State agency, such as the Department. Therefore, the worker must explore a veteran's eligibility for VA funeral payments prior to approving a request for payments of burial expenses.

- J. Potential for RSDI lump sum death payment. As of August 31, 1981, the Lump Sum Death Payment (LSDP) from Social Security is no longer paid directly to funeral homes or to an individual who paid for the burial of the deceased. Under the new provision, the LSDP will be paid in the following order of priority:

1. the widow(er) of the deceased wage earner (DWE) who was living in the same household as the DWE at the time of death;
2. the widow(er) who is entitled (or would have been entitled had a timely application been filed) to benefits based on the DWE's record for the month of death;

NOTE: This category does not include individuals who are entitled (or would have been entitled) to divorced spouse's benefits.

3. in equal shares, to each child who was entitled (or would have been so entitled had a timely application been filed) to benefits based on the DWE's record for the month of death.

If there is no surviving widow, widower, or child as defined above, no lump-sum is payable.

The 1981 amendments also provide that the total LSDP payable will be fixed at \$255.

EXAMPLE:

On 3/03/81, the eligibility worker receives a telephone call from Mr. Mort's daughter. The daughter states that Mr. Mort died in the nursing home on 3/2/81. She explains that the family cannot afford to pay the cost of burial. A representative of the nursing home had suggested that Medical Assistance might be able to supplement the burial costs. She requests that the worker contact her brother who was Mr. Mort's representative.



The worker reviews the case record and finds that Mr. Mort has one life insurance policy with a face value of \$150 that names a funeral director as beneficiary (see 5171).

The worker then contacts Mr. Mort's son, who explains that he has made arrangements with a funeral home for the burial at a cost of \$500. The son requests that the Department assist in the payment of funeral expenses. The worker requests that the funeral director send an itemized bill indicating the total cost of the burial and listing any payments received or anticipated. Since the total cost of the burial does not exceed \$500, the Department may assist in paying Mr. Mort's burial expenses.

The worker contacts the nursing home to inquire if Mr. Mort had any funds in a personal needs account. The nursing home administrator states that Mr. Mort has \$60 in PNA funds that is being sent to the Assignment Collection Unit along with an A-1. Mr. Mort's son or the funeral home director may request the monies from the PNA by submitting the funeral bill to:

Deceased Recipient's Unit  
Accounting Division 5<sup>th</sup> flr.  
Office of Finance  
600 Washington Street  
Boston, MA 02111

The resources available to Mr. Mort's estate total \$210 (\$60 PNA and \$150 life insurance). Although he received Social Security benefits, there will be no RSDI death benefit since Mr. Mort has no surviving spouse or dependent child.

The worker informs Mr. Mort's son that the Department will pay \$290.00 toward the funeral expenses.

When the worker receives verification of the funeral expenses, he completes a PA-33A made out to the funeral home. The procedure code for issuance of PA-33As for burials is 541. See section 7530 for instructions concerning the completion of a PA-33A.



7130: Reimbursement of Certain Recipients for Out-Of-Pocket Expenses

In accordance with the provisions of Section 507.130, individuals who have applied for SSI benefits and, have had the application denied by the Social Security Administration (SSA) or who have applied for AFDC or Medical Assistance and have had the application denied by the Department, and who have subsequently had the denial overturned, are entitled to reimbursement by the Department for certain medical expenses that they paid during the period of erroneous denial. Recipients who have had their SSI application denials reversed after January 1, 1977 are eligible for reimbursement under these provisions.

Reimbursement is limited to bills for care or services that would have been covered by Medicaid and that were incurred on or after the date of initial Medicaid eligibility, that is, the date of initial eligibility for SSI, AFDC, or MA benefits as determined by the appeal decision. These bills must have been paid between the date of the notice of erroneous denial and the date the recipient is notified of Medicaid eligibility, that is the date of receipt of the first MA card, or the date the MA/NFL-3 or AFDC approval notice was received. The bill must have been paid by the recipient, his or her spouse, the parent of a minor recipient, or a legal guardian, in order to be reimbursed. (Medical insurance premiums are a reimburseable expense for a person who was forced to self-insure while awaiting the reversal of the Department's erroneous denial of Medicaid.)

NOTE: A bill will be considered to have been paid by such a person even if the funds used for payment were borrowed from some other source.

If the recipient applies and is eligible for retroactive MA benefits and has incurred bills during that time, reimbursement would be subject to the same standards as above.

Example:

Mr. C applied for SSI-D on April 6. His application was denied on June 10. He appealed the decision and it was overturned in November. His SSI benefits were established effective April 6. After receiving his first MA card on December 1, he came into the local welfare office and completed an SS-37A to cover bills incurred in January and February. He was determined to be eligible for three months' retroactive benefits from the date of his original application. Mr. C must be told that he may submit for reimbursement the bills that he incurred from January 1 through November 30 that he (or another appropriate person) paid between June 10 and November 30.

Verifications

A. SSI recipients are required to provide documents from the SSA establishing:

1. the date of denial of SSI benefits. If the recipient does not have his original denial notice, then he or she must obtain a written statement from SSA;

2. that the decision to deny benefits was overturned. The recipient should bring in the notice advising him or her that this decision was reversed.

B. SSI, AFDC and MA recipients must provide all of the following:

1. Bill(s) for medical service(s) that include(s):
  - . the provider's name, address and MA Provider number when applicable;
  - . a description of the service(s) provided; and
  - . the date the service(s) was provided.

NOTE: If the bill(s) is not available, or does not have the necessary information, you must give the recipient a Request for Reimbursement Information from the Provider (RRIP) (F7130) to be completed by each provider. A copy of each RRIP should be filed in the case record.

2. Proof of payment of the bills, such as a cancelled check or receipt, must be presented.

If the recipient does not have proof of payment, he or she must obtain a statement from the provider on his letterhead or the RRIP. This statement must include any information regarding third party payment.

C. Recipients must be questioned about health insurance and requested to provide a copy of the claim number.

You must assist the recipient whenever necessary, in obtaining necessary verifications.

#### Payment

After all the necessary verifications have been received, you must fill out and submit the Invoice for Special Services using procedure code 940. Instructions for the completion of the Invoice for Special Services may be found in the Systems Manual. The verifications should then be filed in the case folder.

#### 7131: Reimbursement of Recipient Pending Approval for Cash or Medical Assistance

Applicants who have paid for medical services they received pending approval of SSI, MA or AFDC should be advised that reimbursement for these out-of-pocket expenses is also possible. If the recipient had paid a Medicaid provider for services provided between the application date and the date of approval, he or she may seek reimbursement from the provider directly. The provider should then bill Medicaid for the service after reimbursing the recipient.



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F7130: Request for Reimbursement Information from the Provider (RRIP)



CHARLES M. ATKINS  
Commissioner

## *The Commonwealth of Massachusetts* *Executive Office of Human Services* *Department of Public Welfare*

Dear Provider:

\_\_\_\_\_ of \_\_\_\_\_  
(name) (address)

has been found eligible for Medicaid for the period \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_.  
If (s)he paid you directly for any medical services during this period, (s)he may  
be eligible for reimbursement from the Department of Public Welfare.

In order to reimburse the recipient, we need you to fill out the bottom portion of  
this form. (Or, if all of the information requested below appears on your patient  
statement, you may simply provide a copy of the statement.)

Thank you for your cooperation. If you have any questions regarding this, please  
call \_\_\_\_\_  
(Local Office Number)

Very truly yours,

\_\_\_\_\_  
Financial Assistance Social Worker

-----  
Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Medical Provider No. (if any) \_\_\_\_\_

Date(s) of Service	Description of Service	Amount Billed for Service	Amount(s) of Patient Payments	Date(s) of Patient Payments	Third-Party Payments (incl. category 04 Medicaid)
_____	_____	_____	_____	_____	_____

RRIP





7200: TRANSPORTATION

Under certain circumstances, the MA program pays for transportation for medical services. Persons meeting specific criteria may be eligible for non-medical transportation provided by the Travelers Aid Society of Boston under contract to the Department. (See 7250: Transportation Assistance Program.) Regulations governing the provision of medical transportation are promulgated in the Transportation Manual of the Provider Manual Series, 106 CMR 407.400 et. seq. These regulations are the final authority in issues addressing medical transportation. Provisions relevant for the eligibility worker either as background information or instruction for the authorization of medical transportation are summarized herein.



7201: Providers of Transportation

The certification of providers, the standards to be maintained, and the rates that may be charged are determined and monitored by the Provider Division of the Medicaid Division. Any inquiries from providers of medical transportation should be referred to Medical Transportation listed in the Medicaid Directory in the appendix.

7202: MA Transportation Specialist

In some local offices a single person may be designated to handle all MA transportation requests. This person is known as the MA Transportation Specialist. This section describes the responsibilities of the MA Transportation Specialist when such a system is in effect. When a Transportation Specialist has not been designated, the eligibility worker assumes responsibility for the authorization of transportation for his or her caseload.

Materials and Supplies. The following materials and supplies are required when a single staff member handles all transportation requests for the unit:

- A. a ledger or date book with a full page for each day of the year (Log Book);
- B. a recipient card file; and
- C. prior authorizations (MA-11 forms) filed alphabetically by month.

Responsibilities of Transportation Specialist. The MA Transportation Specialist is responsible for the following activities:

- A. compiling local transportation information including bus schedules, train schedules, and a list of dial-a-ride and taxi companies which accept Medical Assistance recipients;
- B. receiving requests from recipients for transportation assistance;
- C. evaluating transportation requests and completing prior authorization forms;
- D. consulting with the Medical Assistance Program at Central Office as required;
- E. receiving requests from recipients for reimbursement of costs incurred in traveling to medical care;
- F. evaluating and processing requests for reimbursement; and
- G. sending copies of all prior authorizations (MA-11 forms) issued each month to Central Office.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

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In this system the dial-a-ride and taxi providers accept calls only from the CSAO/WSO/LTCU. Recipients requesting transportation directly from the taxi company are referred to the CSAO/WSO/LTCU for prior authorization.

Additional Daily Activities. The following activities must be performed on a daily basis by the MA Transportation Specialist.

- A. Each morning the MA Transportation Specialist must check the Log Book for that day and call the dial-a-ride and/or taxi company dispatcher to give him or her the schedule for that day. Whenever possible, the MA Transportation Specialist and the dispatcher should group recipients going to the same destination at approximately the same time.
- B. If any recipients call the CSAO/WSO/LTCU to cancel transportation for that day, the MA Transportation Specialist immediately writes "cancelled" next to the recipients' names in the Log Book under appropriate dates. Some offices make up several monthly prior authorizations for dialysis patients at one time and file them ahead in the prior authorization file.
- C. At the end of each month the MA Transportation Specialist must send copies of all M-11 forms issued that month to Central Office.



7210: Eligibility for Benefits

The Department pays for transportation services provided to Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08) subject to the restrictions and limitations described in 106 CMR 407.000. The Department does not pay for transportation services provided to General Relief recipients (category of assistance 04).

7211: Project Good Health

The Department must offer and provide, when appropriate under policy provisions, transportation services to all Medical Assistance recipients under 21 years of age to facilitate their access to comprehensive health care.

At the time of application for Medical Assistance, recipients should be told about available transportation services. Recipients should be urged to use family, friends, neighbors, and public transportation to obtain medical care, but they should also be informed that other types of transportation are available upon proper medical need, prescription and authorization.

7212: Responsibilities of Recipient.

It is the responsibility of the recipient to perform the following activities:

- A. to obtain a prescription to verify the medical necessity for transportation;
- B. to request transportation assistance from the WSO/CSAO/LTCEU;
- C. to contact the transportation provider to make arrangements for pickup, if required; and
- D. to obtain receipts and documentation necessary to apply for reimbursement of costs, when applicable.

7213: Covered Services

Transportation services are reimbursable only when recipients are traveling to obtain medical services paid under the Medicaid Program. Transportation to a chiropractor's office is not reimbursable.

7214: Restrictions on Medical Transportation

When transportation is by taxi, dial-a-ride, bus, or public transportation, it is the responsibility of the recipient's WSO/CSAO/LTCEU, to determine those medical services that are covered under the Medical Assistance Program per 106 CMR 407-411-4. When transportation is by ambulance or chair-car, it is the responsibility of the transportation provider to determine which medical services are covered and to advise the recipient in instances when transportation is requested for service that, in the provider's judgment, may not be or is not covered. If a recipient is in doubt as to whether or not a service is covered, he should contact the local WSO/CSAO/ LTCEU.

Each type of transportation has specific restrictions applied to its use. The Transportation Manual details the documentations and forms necessary to the approval of each type of transportation service. In addition, all transportation services are subject to the following restrictions.

A. Locality Restrictions

In general, the Department will pay for a recipient to be transported to sources of medical care within the recipient's locality only. Locality refers to the town or city in which the recipient resides and to immediately adjacent communities. However, when necessary medical services are unavailable in the recipient's locality, medical transportation to the nearest medical facility in which treatment is available is reimbursable.

B. Restrictions on Type of Transportation

Recipients must utilize personal transportation resources such as family or friends whenever possible. When personal transportation resources are unavailable, a recipient must utilize public transportation, if available in the locality and suitable to his or her medical condition. Private transportation is reimbursable only when public transportation is suitable to the recipient's medical condition is unavailable.

C. Restrictions on Institutionalized Recipients

When specialized equipment required for medical treatment is not available at a facility, the infirm recipient may be transported to the site of such specialized equipment. Medical services that may require specialized equipment include services such as: X-ray services, cast removal, fitting for artificial limbs, and radiation therapy.

D. Shared Ride

When two or more recipients are traveling to the same destination at the same time, they must share transportation when such arrangements are made by the Department, the transportation provider, or the medical provider.

7215: Authorization Requirement for Taxi or Dial-a-Ride Services

Authorization Requirement. All dial-a-ride or taxi transportation requires prior authorization from the recipient's WSO/CSAO/LTCEU. The Department will grant a prior authorization only when the request is accompanied by a completed physician or dentist's prescription, if required. Prior authorization is for health-care necessity only.

Consultation with Regional Medical Unit or Medical Division.

In the following situations, the person designated by the WSO/CSAO/LTCEU to be the Medical Assistance transportation specialist must consult with the Medical Division before granting prior authorization for dial-a-ride or taxi transportation (prior Approval Unit, See Appendix):

- A. when the recipient is traveling outside his or her locality to obtain medical care;
- B. when there is recurring need (eight or more trips per month to the same destination for a period of two months or more); and
- C. when the medical necessity is questionable.

7216: Authorization Requirement for Chair Car or Ambulance

Authorization Requirement. A Medicare/Medicaid Medical Necessity Form serves as authorization for chair-car transportation, except in the following instances when prior authorization from the Medical Division is required:

- A. the second and succeeding round trips provided to the recipient in the same day;
- B. transportation to a medical provider outside the recipient's locality;
- C. all out-of-state transportation, except when the destination is a town or city within the recipient's locality;

7216 (con't)

- D. trips from one skilled nursing or intermediate care facility to another when no change in level of care is involved; and
- E. transportation between like hospitals (chronic to chronic, acute to acute), except when lack of necessary medical services or knowledge of the recipients medical history at one hospital requires transfer to another.



7220: Reimbursement to Recipients for Transportation Expenses7221: Reimbursable Expenses

Recipients may obtain direct reimbursement from the Department for expenses incurred in traveling to reimbursable medical care.

Reimbursement for transportation is limited to the following expenses:

- A. private automobile costs, when the use of a private automobile is less expensive than other available transportation;
- B. public transportation costs (MBTA, local buses);
- C. any licensed carrier costs, when there is no transportation provider in the recipient's locality and when documentation of medical necessity for the mode of transportation used can be provided by a physician; and
- D. dial-a-ride or taxi transportation costs in cases of urgent medical need, when the recipient's Welfare Service Office is closed.

7222: Method and Amount of Reimbursement

- A. In order to obtain reimbursement for transportation expenses, a recipient must obtain documentation from his physician, registered nurse, or medical-facility social worker that reimbursable medical services were received. The documentation must give the date on which medical services were received as well as the specific address where medical services were received. In cases of urgent medical need, the documentation must also state the time medical services were received to verify that the Welfare Service Office or Community Service Area Office was closed. Transportation receipts are also required when available. The recipient must submit documentation and receipts to his local Welfare Service Office and request reimbursement for transportation expenses.
- B. Transportation costs must total \$10.00 or more in order for the recipient to request reimbursement. The recipient must request reimbursement no later than 90 days after the earliest date on which transportation costs in excess of \$10.00 were incurred. The amount of reimbursement for automobile costs shall be the lesser of either the automobile mileage cost as calculated from the Department's mileage manual utilizing the reimbursement rate currently authorized for Department employees, or the cost of other available transportation.



7222 (con't)

- C. If a recipient traveled outside his locality, the documentation must state that the medical services were needed and that they could not be obtained locally. If a recipient traveled outside his locality when necessary medical services were available locally, transportation costs incurred are not reimbursable.

EXAMPLE OF REIMBURSEMENT:

Anna Mobile presents documentation and receipts for transportation expenses to the WSO's designated MA Transportation Specialist.

- A. Review of Documentation and Receipts. The designated MA Transportation Specialist reviews documentation and receipts to determine that:
1. the recipient received medical care on the day(s) for which reimbursement is being requested.
  2. the recipient traveled to medical care within her locality, and if not, that the documentation states what medical services were needed that could not be obtained locally; and
  3. if the reimbursement request is due to "urgent medical need" and when services were received to verify that the WSO/CSAO/LTCEU was closed.
- B. Determination of Amount of Reimbursement. The designated MA Transportation Specialist totals receipts, public transportation fares (for which receipts are usually not available) and automobile mileage costs to determine amount of reimbursement. Automobile mileage costs are calculated from the Department mileage manual utilizing the reimbursement rate currently authorized for Department employees. Tolls and parking fees are not reimbursable.
- C. Completion of Forms. If review of documentation and total amount of costs incurred indicate that reimbursement should be made, the designated MA Transportation Specialist completes a Massachusetts Department of Public Welfare Non-Medical vendor Payment System Invoice (Form PA-33A) entitled "Authorization and Claim for Non-Medical Services."

All claims for reimbursement for transportation to medical care utilize procedure code 900.

## 7230: SUMMARY TABLE OF MA TRANSPORTATION REQUIREMENTS

TYPE OF TRANSPORTATION	REQUIRED DOCUMENTATION	FORM + DISTRIBUTION	TRANSPORTATION MANUAL SECTION
Reimbursement for public transportation or automobile (in locality)	Type of service, date(s) of service and need from medical provider	PA-33A to recipient for costs of public transportation or 20¢/mile	
Reimbursement for bus, public transportation or private auto (out of locality or more than 7 trips/month)	Same as above plus statement from physician that services weren't available locally. Receipts when available	Same as above	
Taxi/Dial-a-Ride (in locality)	PT-1 form or statement from medical provider re: physical condition *1	M-11 (Prior Authorization Form) 1 copy to case record 1 copy to Central Office (monthly) 2 copies to transportation provider	
Taxi/Dial-a-Ride (out of locality or more than 7 trips/month)	Same as above; plus approval from Medical Division	Same as above	
Chair Car/Non-Emergency Ambulance (in locality)	Medical Necessity Form (MNF) completed by medical provider (approval from Medical Division in special situations. see 8110)	Transportation provider submits completed MNF to Central Office	
Emergency Ambulance	No form required. Hospital records must support the use of ambulance	--	407.484
Boat, Bus, Train (in locality)	Type of service, date(s) of service and need from medical provider. Prior approval from WSO/CSAO	M-11 to licensed carrier (2 copies) One copy to case record One copy to Central Office	407.492-494
Boat, Bus, Train (out of locality or more than 7/trips/month)	Same as above plus statement that service was not available locally	Same as above	407.492-494
Taxi/Dial-a-Ride Urgent Need	PT-1 form or statement from medical provider within 2 business days of service	M-11 form same as above	407.456/407.443

\* Not necessary if no public transportation is available in locality

7240: Transportation for DSS Children

DSS staff are not authorized to make determinations of eligibility for medical transportation for their clients. Only DPW staff can determine eligibility. Therefore MA workers are responsible for completing prior authorization of transportation for DSS placements. This section describes the prior authorization process and lists the DSS offices and the CSAO/WSO's responsible for DSS children handled by each DSS office.

7241: Prior Authorization for Medical TransportationDSS Responsibilities

- A. To present verification to designated DPW transportation person that children are receiving services from DSS and are eligible for MA. One of the following is acceptable verification:
  - 1. a current MA Identification Card
  - 2. a copy of the POS-8 used to establish the case on the POS-8 Masterfile showing that the DSS case is active.
- B. To obtain prescription for medical transportation (PT-1 form) when required.
- C. To present PT-1 form to the MA transportation person.
- D. To request transportation assistance from the correct DPW office (see list of DSS and corresponding DPW offices).

7242: DPW Transportation Person's Responsibilities

- A. To obtain all PT-1 forms for DSS cases.
- B. To evaluate any request for prior authorization of transportation from DSS, using the criteria explained in section 7200 of the Procedures Handbook.
- C. To complete the M-11 (if transportation is approved) paying particular attention to the following blocks:
  - 1. Recipient Name (Block 5) - Enter the name of the eligible DSS child.
  - 2. Region Number (Block 7) - Always enter Region 09 for DSS cases.

7242 (con't)

3. Office Number (Block 8) - Always enter the DSS Area Office Number (see list of DSS and DPW offices in Appendix).
4. Category (Block 9) - Always enter category 08 for DSS cases.

DPW CSAO/WSO Director (or Designee) Responsibilities -

- A. Assign an appropriate person to process transportation requests for DSS cases.
- B. Ensure that all of the above procedures are followed for DSS cases.





7250: Transportation Assistance Program (TAP)

Under certain circumstances, the Department provides transportation assistance to recipients of MA, SSI and RRP (as well as AFDC and GR), enabling such persons to move outside the Commonwealth. Transportation assistance may also be available to persons who would be eligible for categories 0-8 if they applied, even though they do not actually participate in one of these programs. This assistance is provided by the Travelers Aid Society of Boston under contract to the Department. Assistance is limited to personal transportation and does not cover the costs of moving household goods or furnishings. The MA worker is responsible for making appropriate referrals to Travelers Aid. That agency will in turn make a determination of eligibility and provide the assistance.

If an individual or family requests assistance in moving out of the Commonwealth, the MA worker must determine if the referral is appropriate. Persons requesting assistance must meet all of the following criteria:

1. have a significant social, medical, or financial problem which may be substantially alleviated by moving outside the Commonwealth;
2. be a recipient of, or appear to be eligible for MA, SSI, or RRP;
3. have insufficient resources to move outside the Commonwealth; and
4. have not previously participated in the Transportation Assistance Program.

If the recipient appears to meet these guidelines, the worker contacts Travelers Aid (617-542-7286) to arrange a face to face interview with the recipient. The worker completes two copies of the TAP-1 (See F7250), gives the original to the recipient, and places the copy in the case record. Once Travelers Aid has processed the request, the original TAP-1 is returned to the worker with a description of the action taken. This copy is filed in the case record.

If a recipient files an appeal as a result of the decision made by Travelers Aid, Travelers Aid staff will represent the Department at the appeal hearing.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

## F7250: TRANSPORTATION ASSISTANCE PROGRAM REFERRAL FORM (TAP-1)

### TRANSPORTATION ASSISTANCE PROGRAM REFERRAL FORM FROM THE DEPARTMENT OF PUBLIC WELFARE

T0: Travelers Aid Society, 312 Stuart St., Boston, MA 02116

DATE: \_\_\_\_\_

Travelers Aid Worker Contacted \_\_\_\_\_

Recipient Name	SSN
Other Adult Name (if any)	SSN
Address	City or Town
Category-Circle One: AFDC                      GR                      MA                      SSI	Phone Number

#### Other Family Members

Name	Age	Name	Age

The above named person(s) is a recipient of the indicated category and has requested benefits under the Transportation Assistance Program. The circumstances surrounding the request are as follows:

Destination

FAW \_\_\_\_\_

CSAO/WSO Phone \_\_\_\_\_

CSAO/WSO Address \_\_\_\_\_

Action Taken by Travelers Aid	
Travelers Aid Worker	Date

TAP-1

7300 PROJECT GOOD HEALTH

Project Good Health (PGH) is designed to provide preventive health care to all children, adolescents, and young adults under the age of 21 who are eligible for Medical Assistance. This includes the parents of a child if the parents are also under the age of 21. Services can be obtained immediately through the issuance of a temporary card to applicants whose eligibility is established.

The Project is administered jointly through the cooperation of Project Good Health specialists and Assistance Payments and Medical Assistance workers who make referrals to the PGH specialists. Recipients of cash assistance programs who are automatically eligible for Medical Assistance are advised of Project Good Health by the appropriate Assistance Payments workers. The procedures provided herein apply to the responsibilities of the Medical Assistance worker for the provision of services to Medical AssistanceOnly recipients.

PGH Regulations

The Department's regulations governing Project Good Health are promulgated in the Project Good Health Manual, 106 CMR 418.000, the fourth of the new Provider Manuals. The information provided in this section of the Worker Handbook repeats or summarizes material that is of use to the Medical Assistance eligibility worker. The regulations promulgated in 106 CMR 405.000 and 433.000 are the final authority.

7310: Provision of Information7311: Worker Responsibilities

The objective of Project Good Health is early and periodic screening to ensure that health problems are not developing and that the child is growing normally.

Providing information on the goals and benefits of Project Good Health is a primary ingredient in the success of the program. Due to the limited opportunities that the worker has for personal contact with the applicant or recipient, reliance is placed on written material provided through the mail. The Department supplies workers with copies, in appropriate languages, of information and promotional literature which describe and explain the PGH Program.

7312: Pamphlets

The eligibility worker must enclose PGH literature with each Medical Assistance approval letter to recipients who are under the age of 21 or have eligible children under the age of 21.

The pamphlets describing Project Good Health have recently been revised. New Department pamphlets are:

- A. "Project Good Health"
- B. "Protect Their Tomorrows"
- C. "Good Health...Before the Baby is Born"    Pre-Natal
- D. "The Early Years...Starting Healthy"        0-2 Years
- E. "The Middle Years...Growing Healthy"        3-11 Years
- F. "The Teenage Years...Staying Healthy"        12-21 Years

The pamphlets "Project Good Health" and "Protect Their Tomorrows" should be provided to all assistance units with persons under 21 years of age. Additional pamphlets should be provided in accordance with the age of the children in the unit.



7330: Referrals

When an applicant or recipient of Medical Assistance expresses an interest in the program, the worker or the recipient must complete Form PGH-21 or page 9 & 10 of the SS37. This documents the worker's efforts and ensures program participation and follow-up of interested recipients.

The worker requests that the recipient complete Form PGH-21 or page 9 & 10 of the application/retermination form. The original will become part of the case record. A copy of the completed form must be sent to the PGH specialist. As PGH information is updated, a copy of the form with the recorded changes must be forwarded to the PGH specialist. If the applicant fails to complete pages 9 & 10, the worker must complete them, and send a copy to the PGH specialist.

When a recipient requests information on participating providers, the worker must provide a list of participating PGH providers located in the applicant's or recipient's area and offer to assist in the selection of a provider.

7331: Scheduling Health Care Appointments

When a recipient requests assistance in scheduling health care appointments, the worker is obliged to assist. The worker must schedule appointments to occur within 60 days of the date of request.

7332: Authorization of Medical Transportation

Transportation to and from the first appointment for the services of Project Good Health may be authorized under the provisions for medical transportation. See Handbook Section 7200.

7333: Referral for Child Care or Translation Services

If the recipient is in need of child care or translation services in order to obtain the PGH appointment, the worker should make a referral on Form SOC-7 to the PGH specialist.

7334: Notification to PGH Specialist

When any of the PGH-related assistance listed above is provided, the worker must notify the PGH specialist according to the following guidelines.



7334 (con't)

- A. If the worker provides assistance for PGH services during the intake or redetermination process, he should record the type of assistance provided on PGH-21 and send a copy to the PGH specialist.
- B. If the assistance is requested and provided at any other time, the PGH specialist should be notified of the type of assistance on SOC-7, Informational or Referral Communications.

7335: Responsibilities of the PGH Specialist

The PGH specialist is an employee of the Department assigned specifically to the PGH Program, whose principal function is to ensure the timely delivery of the services to PGH recipients.

PGH specialists are located in the Department's CSAO's. Each PGH specialist works under the supervision of the PGH Program in the Medical Division. The responsibilities of PGH specialists are specified below.

- A. Outreach. PGH specialists supplement the efforts of Assistance Payments workers to explain the PGH Program and its advantages, by means of outreach letters to PGH eligible households. Questions from recipients regarding PGH outreach letters should be referred to the PGH specialist.
- B. Assistance. PGH specialists assist those recipients who need or request further outreach and information to choose and make appointments with PGH providers (whenever possible) and to overcome barriers that hinder receipt of satisfactory and comprehensive health care. The PGH specialists also identify eligible persons who are in need of those health services provided under the authority of Title V of the Social Security Act, inform such persons about the services, and make referrals whenever appropriate.
- C. Liaison. PGH specialists maintain liaison between the Medical Division and local health-care providers. Their liaison duties include the promotion of provider participation, the provision of assistance to providers, and the development of provider alternatives.
- D. Follow-Up. PGH specialists must follow up in all cases in which a recipient has received assistance from Department staff to obtain health-care services, in order to ensure that services were received within a prescribed time period and were satisfactory.

7335 (con't)

- E. Documentation. PGH specialists create and maintain records designed to identify the status of recipients in the PGH Program.
- F. Promotion. PGH specialists promote interest in the PGH Program among recipients and providers through personal contact with recipients, public-interest advertising, promotional events, and contact with public and private agencies and groups.



7400: MEDICAID PROGRAMS

Medicaid services are provided to recipients of MA through medical providers who participate in the Medical Assistance Program. While workers are not expected to know or interpret Provider Regulations, they should be able to refer questions from providers and recipients to the appropriate unit in the Medicaid Division. The Medicaid Directory lists the unit responsible for program regulations that apply to a particular program (see Appendix).

This section describes Medicaid's program that are available to recipients in categories 00, 02, and 05-08 as well as SSI recipients. Recipients may be assigned to or enrolled in these programs.

7410: Case Management Programs - Available to 02 Recipients Only

Community Health Plans usually offer at minimum all the services available in a physician's office in addition to nutrition, health and social services and emergency care. Services are billed as provided by the Health Plan. It is hoped that cost savings will be realized by providing comprehensive health care in one setting. Enrollees obtain other services through referrals from their primary provider.

Case Management outreach workers contact eligible recipients to inform them about the program and to enroll those who are interested. Interested AFDC households should be referred to the appropriate health plan.

Restrictions

Case Management enrollees are entitled to comprehensive medical services through the direction of their case management site and are eligible for very few services outside of the direction of the site. The Department will pay a provider for only those services specified as reimbursable on the recipient's Medicaid Eligibility Card. The provider must obtain approval from the case management site before furnishing any service that is not listed as reimbursable on the Medicaid Eligibility Card.

How Coded

Case Management codes are entered on the Recipient Master File by Central Office. These codes appear in the health insurance block of the Recipient Master File, on the MA ID card, and on the turnaround document. A copy of the recipient's enrollment form is sent to his WSO to inform Financial Assistance workers of the recipient's enrollment. This copy should be placed in the recipient's file and should be referred to when conducting a redetermination. Make sure to correctly code in the turnaround document when doing a redetermination. If a "Z" appears in the health insurance block instead of the correct Case Management code. Medicaid claims may be paid in error. When asking a recipient about health insurance coverage, be sure to ask specifically whether or not the family participates in the Case Management Program.



7420: Health Maintenance Organizations (HMO'S)

A health maintenance organization (HMO) is a prepaid health plan that offers most health services at one location. Because the membership fee covers all necessary medical services offered, the HMO has an interest in keeping its membership healthy. The emphasis in HMO's is on preventative medicine.

Each member chooses his own primary physician or health care team. Services may not be obtained from providers other than the HMO unless emergency care is required or the service is unavailable at the HMO. In such cases the primary physician must make the referral.

All HMO's may enroll AFDC recipients, certain HMO's enroll category 06 and 08 recipients as well. Enrollment is accomplished by contacting the HMO recruiter or through his outreach efforts (See Medicaid Directory).

7430: The Medication Control Program

The Medication Control Program was established to prevent recipients of Medical Assistance from obtaining excessive quantities of prescribed medications through multiple visits to physicians and pharmacies, i.e., "shopping". Regulations for the Medication Control Program are found in Chapter VII, Section J, Part 4 of MPAPM.

Recipients of AFDC, MA-only, and SSI are reviewed by the Medicaid Division for possible placement in the program. When placed, recipients choose a primary pharmacy to which they are restricted for all prescription services. The Department notifies each primary pharmacy of the identity of recipients restricted to that pharmacy. The Department also sends a list of the Medicaid identification numbers and primary pharmacies of restricted recipients to all pharmacies participating in the Medical Assistance Program. The Department will not pay a pharmacy other than the recipient's primary pharmacy for prescription services furnished to a recipient whose Eligibility Card bears this restriction message.

A recipient placed in the Medication Control Program may change his or her primary pharmacy, but only at intervals of 60 days or more. He must notify the Pharmacy Program Director at least 30 days prior to the change and complete a new Primary Pharmacy Selection Form; CSAO/WSO/LTCEU's cannot approve any emergency prescriptions for restricted recipients. The Medical Assistance Division will authorize the approval of emergency prescriptions.

7431: Notification

To Recipients. Recipients identified as "shoppers" are notified by registered mail with an appeal form. Recipients placed in the program are requested to select, within 10 days, a single pharmacy (Primary Pharmacy) from which to obtain all prescription medications.

Those who do not respond within 10 days are assigned a primary pharmacy by the Medicaid Division. Recipients restricted to a primary pharmacy will receive Medicaid Eligibility Cards with the following restriction message: "Medical Control: Recipient Restricted to Primary Pharmacy".

If one member of the family is identified as obtaining unnecessary or duplicate prescribed drugs from several different pharmacies, the entire family is restricted to the primary pharmacy.

Each primary pharmacy will be notified of those recipients restricted to that pharmacy. All pharmacies previously utilized by the recipient prior to restriction will receive a monthly updated list of recipients by MA identification numbers only, matched with their primary pharmacies. This list is for use by pharmacies in identifying at which primary pharmacy a restricted recipient must receive all of his prescribed medications.

CSAO/WSO/LTCEU Directors will be advised of all restricted recipients enrolled in the program and their primary pharmacies by means of the Medical Control Program Identification form (MCP-11). Restricted recipients will be listed alphabetically within the CSAO/WSO.

7432: Right to Appeal

A recipient who has been placed in the Medication Control Program has the right to appeal this Department action. All standard appeal procedures apply. There is no responsibility on the part of the CSAO/WSO/LTCEU staff to attend hearings or to participate in Medication Control Program appeals.

7433: Responsibilities of the Eligibility Worker

The eligibility worker has the following responsibilities in the Medication Control Program. The worker:

- A. receives copies of MCP-11 which identifies restricted recipients for placement in recipients' case records;
- B. when issuing a temporary Medicaid Eligibility Card including those for reopened cases, workers must check: 1) case record of recipient for MCP-11 to determine restriction status, and 2) supervisor's control copy of MCP-11;

7433 (con't)

- C. arranges for temporary Medical Eligibility Card to be typed assuring that correct restriction message is included;  
(Medication Control-Recipient Restricted to Primary Pharmacy)
- D. places carbon copy of temporary Medicaid Eligibility Card in recipient's case record;
- E. receives photocopies of notice of change in recipient status in the Medication Control Program form (MCP-11) and places them in appropriate case records; and,
- F. recipients with address and telephone numbers of Medication Control Program if requested. Workers are not responsible for answering inquiries relative to the Medication Control Program other than general information. All inquiries will be referred to the Medical Assistance Division.

7434: Transfer of Restricted Cases

Recipient Responsibilities. The recipient must notify the Pharmacy Program Director in the Medical Division of new address and of need for change in primary pharmacy at least 30 days prior to relocation. The recipient must select a new primary pharmacy on Primary Pharmacy Selection Form.

Medicaid Division Responsibilities. When the Department receives a request from a restricted recipient for a change in primary pharmacy, Central Office staff provides the recipient with the Primary Pharmacy Selection Form.

Reopened Cases

A recipient placed in the Medication Control Program may be removed from the program after a 6-month review of his drug usage. The recipient will be notified by registered mail of the change. The CSAO/WSO and the primary pharmacy will be notified of the change by the Medical Assistance Division by means of Form MCP-11R.

Restricted recipients whose cases are closed and then reopened, will receive computer generated Medicaid Eligibility Cards with the restriction message when the case reopens until they are removed from the Medication Control Program by the Medical Assistance Division.



7440: Case Management Screening Program

The Department will approve skilled nursing and intermediate care facility services only for recipients for whom the requirements of 106 CMR 202 - 206 are met. To ensure that each patient is placed at the appropriate level of care, Case Management Screening Programs (CMSP) have been set up to serve most communities throughout the state.

CMSP Teams, also known as Placement Review Teams, consist of a nurse and a social worker who review the patient's medical records and the physician's recommendations. They interview the patient and his family and explore alternatives in the community, such as homemaker services, home health agencies, meals on wheels, transportation, adult foster care, etc.

Any person whose residence is in a community served by a CMSP Team must have the team's approval before his case may be coded on FMCS and MMIS for long-term care payment. Section 7441 provides a list of CMSP sites and the cities and towns covered by each.

Admission

When a resident from one of these communities is ready for discharge from an acute hospital, the hospital must forward to the CMSP Team all required documentation substantiating the recipient's need for the level of care requested. The hospital must also seek the assistance of the CMSP Team in finding placements for MA recipients on Administrative Days.

CMSP sends a Notification Form (F7441A) to the CSAO/WSO/LTCU as well as to the recipient indicating approval or disapproval for long-term care placement. An appeal form accompanies each denial, and CMSP Team members represent the Department if a fair hearing is requested. If the individual is disapproved for long-term care, eligibility must be determined according to community standards.

If the individual is determined to need long-term care, the Level of Care (3D or 3E) is entered beside LOC in the block at the bottom left corner of the form. The date of CMSP approval will be provided on the next line, or, if CMSP approval was given prior to a placement being found for the individual, the date block will state "date of admission to facility".

(If the CMSP Notification Form shows that the approval is for short-term care only, see Section 6222: Maintenance of a Former Home.)

Section 7442 lists the cities and towns not covered by CMSP as of September 1, 1983. For applicants and recipients residing in these communities prior to the need for long-term care placement, a Patient Care Referral Form from the discharging hospital must be submitted to the CSAO/WSO/LTCU before the case may be coded for long-term care payment (see 2126 and 2323).



Conversion

Persons who are already residing in a nursing home when they become eligible for Medicaid must also be reviewed by CMSP before Medicaid payments to the nursing home are approved. The same basic procedures outlined above apply to such "conversion cases"; however a different form, the Level Change and Conversion Cases Notification Form, (F7441B) is used. If long-term care is approved, the level of care (3D or 3E) is entered in the block at the bottom of the form. The date in these cases will be the "date of MA eligibility".

CMSP in deciding whether or not to approve long-term care payment, considers additional factors such as the length of time the person was in the nursing home before he became Medicaid eligible. If these psychosocial factors indicate that long-term care is needed, even though there may not be a medical need in the strictest sense, the block "Transfer Not Required" will be checked and the box at the bottom of the Notification Form will reflect the LOC that the recipient is being allowed to stay in. If CMSP denies the case, the "Transfer Required" block will be checked, and "DENIED" will be written or stamped in the box at the bottom of the Conversion Cases Form. The case then may not be coded for long-term care payment.

Level Change

Changes in the level of care must also be approved by CMSP (See 2325 and 2326). These approvals are sent to the CSAO/WSO/LTCU on the Level Change and Conversion Cases Form (F7441B).

See Systems Manual M200 for coding of the Long Term Care Source Document.

441: CASE MANAGEMENT SCREENING PROGRAM SITES1. BEVERLY/NORTH SHORE

186 Cabot Street, Beverly 01915  
927-6616 (Centrex 7-6808)

Beverly	Marblehead
Danvers	Middleton
Essex	Peabody
Gloucester	Rockport
Hamilton	Salem
Ipswich	Topsfield
Manchester	Wenham

2. SOUTH SHORE

1458 Hancock Street, Quincy 02169  
471-2600 (Centrex 7-1148)

Braintree	Norwell
Cohasset	Quincy
Hingham	Randolph
Hull	Scituate
Milton	Weymouth

3. BRISTOL COUNTY

P.O. Box 150, Taunton 02780  
824-1383 or 1384

Acushnet	Raynham
Assonet	Rehoboth
Berkley	Rochester
Dartmouth	Seekonk
Dighton	Somerset
Fairhaven	Swansea
Fall River	Taunton
Freetown	Wareham
Marion	Westport
Mattapoissett	
New Bedford	

4. MERRIMACK VALLEY

11 Lawrence Street, Lawrence 01840  
689-2877 or 1-800-322-1448

Amesbury	Methuen
Andover	Newbury
Boxford	Newburyport
Georgetown	North Andover
Groveland	Rowley
Haverhill	Salisbury
Lawrence	West Newbury
Merrimack	

5. FRAMINGHAM/MILFORD

66 Summer Street, Milford 01757  
473-2710

Acton	Lincoln
Ashland	Littleton
Bedford	Marlborough
Bellingham	Maynard
Boxborough	Medway
Carlisle	Milford
Concord	Natick
Dover	Northborough
Framingham	Sherborn
Franklin	Southborough
Holliston	Stow
Hopedale	Sudbury
Hopkinton	Wayland
Hudson	Westborough

6. NORWOOD

P.O. Box 860, 886a Washington Street  
Norwood 02062  
762-6300 Ext. 36

Attleboro	Norfolk
Avon	Norton
Canton	North Attleboro
Dedham	Norwood
Easton	Plainville
Foxborough	Sharon
Holbrook	Stoughton
Mansfield	Walpole
Medfield	Westwood
Millis	Wrentham

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7441

7. BERKSHIRE COUNTY

P.O. Box 576, 46 Summer Street,  
Pittsfield 01201  
499-3250 (Centrex 7-4503)

Adams	New Ashford
Alford	New Marlboro
Becket	North Adams
Cheshire	Otis
Clarksburg	Peru
Dalton	Pittsfield
Egremont	Richmond
Florida	Sandisfield
Great Barrington	Savoy
Hancock	Sheffield
Hinsdale	Stockbridge
Lanesborough	Tyringham
Lee	Washington
Lenox	West Stockbridge
Monterey	Williamstown
Mt. Washington	Windsor

8. PLYMOUTH COUNTY

P.O. Box 150, Taunton 02780  
824-1383 or 1384

Abington	Lakeville
Bridgewater	Marshfield
Brockton	Middleborough
Carver	Pembroke
Duxbury	Plymouth
East Bridgewater	Plympton
Halifax	Rockland
Hanover	West Bridgewater
Hanson	Whitman
Kingston	

9. LYNN/NORTH SUBURBS

1 Washington Square, Lynn 01901  
599-0700

Chelsea	Revere
Lynn	Saugus
Lynnfield	Swampscott
Nahant	Winthrop

10. WORCESTER COUNTY

Old Common Road, Lancaster 01523  
368-8541 or 8542

Ashburnham	Northbridge
Ashby	North Brookfield
Auburn	Oakham
Ayer	Oxford
Barre	Paxton
Berlin	Pepperell
Blackstone	Princeton
Bolton	Rutland
Boylston	Shirley
Brimfield	Shrewsbury
Brookfield	Southbridge
Charlton	Spencer
Clinton	Sterling
Douglas	Sturbridge
Dudley	Sutton
East Brookfield	Templeton
Fitchburg	Townsend
Gardner	Upton
Grafton	Uxbridge
Groton	Wales
Hardwick	Warren
Harvard	Webster
Holden	West Boylston
Holland	West Brookfield
Hubbardston	Westminster
Lancaster	Winchendon
Leicester	Worcester
Leominster	
Lunenburg	
Mendon	
Millbury	
Millville	
New Braintree	

11. MYSTIC VALLEY

1 Washington Square, Lynn 01901  
599-0700

Burlington	North Reading
Everett	Reading
Lexington	Stoneham
Malden	Wakefield
Medford	Wilmington
Melrose	Winchester
	Woburn

12. WESTERN SUBURBS

One Davis Square, Somerville 02144  
666-4910

Arlington	Newton
Belmont	Somerville
Brookline	Waltham
Cambridge	Watertown
Needham	Wellesley
	Weston

13. METROPOLITAN BOSTON

43 Hawkins Street,  
Boston, MA 02114  
727-1420

14. CAPE COD and ISLANDS

P.O. Box 150, Taunton 02780  
824-1383 or 1384

Barnstable	Harwich
Bourne	Hyannis
Brewster	Mashpee
Centerville	Nantucket
Cotuit	Oak Bluffs
Chatham	Orleans
Chilmark	Provincetown
Dennis	Sandwich
Eastham	Tisbury
Edgartown	Truro
Falmouth	Wellfleet
Gay Head	West Tisbury
	Yarmouth

15. SPRINGFIELD CMSP

310 State Street  
Springfield, MA 01105  
(413) 781-0212

Agawam	Montgomery
Belchertown	Palmer
Blandford	Russell
Chicopee	Southwick
East Longmeadow	Springfield
Granville	Tolland
Hamden	Ware
Longmeadow	Westfield
Ludlow	West Springfield
Munson	Wilbraham

16. NORTHAMPTON

383 Dwight Street  
Holyoke, MA 01040  
(413) 536-2550

Amherst	Leyden
Ashfield	Middlefield
Athol	Monroe
Bernardston	Montague
Buckland	New Salem
Charlemont	Northfield
Colrain	Northampton
Conway	Orange
Cummington	Pelham
Deerfield	Petersham
East Hampton	Phillipston
Erving	Plainfield
Gill	Rowe
Goshen	Royalston
Grandby	Shelburne
Greenfield	Shutesbury
Hadley	Southampton
Hatfield	South Hadley
Hawley	Sunderland
Heath	Warrick

17. LOWELL

11 Lawrence St.  
Lawrence, MA 01840  
(617) 689-2877 or 1-800-322-1448

Billerica	Lowell
Chelmsford	Tewksbury
Dracut	Tyngsborough
Dunstable	Westford





## F7441A: CMSP Notification Form

This form, indicating approval by a Placement Review Team of the Department's Case Management Screening Program, is required for any individual entering a Level II or Level III facility from any city or town covered by CMSP. These cities and towns are listed in 7441.



*The Commonwealth of Massachusetts*  
*Executive Office of Human Services*  
*Department of Public Welfare*

CASE MANAGEMENT SCREENING PROGRAM  
 NOTIFICATION FORM

DATE: \_\_\_\_\_

In accordance with Department of Public Welfare regulations 106 CMR 456.201-456.204 and 456.251-456.270, the Placement Review Team of the Department's Case Management Screening Program has reviewed the case of (recipient's name) \_\_\_\_\_  
 Medicaid No: \_\_\_\_\_ and:

☐ Has approved the need for skilled nursing facility (Level II) services.

☐ Has approved the SHORT TERM need for skilled nursing facility (Level II) services: \_\_\_\_\_

Re-evaluate in \_\_\_\_\_ months.

☐ Cannot approve the need for skilled nursing facility (Level II) services at this time because of the following reasons: \_\_\_\_\_

☐ Has approved the need for intermediate care facility (Level III) services.

☐ Has approved the SHORT TERM need for intermediate care facility (Level III) services. \_\_\_\_\_

Re-evaluate in \_\_\_\_\_ months.

☐ Cannot approve the need for intermediate care facility (Level III) services at this time because of the following reasons: \_\_\_\_\_

**RIGHT TO APPEAL:**

The General Laws provide that if you are not satisfied with any action by the Department of Public Welfare, you have the right to appeal and receive a fair hearing before a referee of the Division of Hearings. The request for a fair hearing must be received by the Department within ninety (90) days of the date of this written notice to you of the decision of the Department's Placement Review Team. If you are currently residing in a long-term care institution and you file a request for a fair hearing within ten (10) days of the date on this written notice, no transfer will be required pending the outcome of the hearing.

Attached please find the Department's Request for a Fair Hearing Form.

Placement Review Team Member (name) \_\_\_\_\_

LOC: \_\_\_\_\_ (signature) \_\_\_\_\_

DATE: \_\_\_\_\_

LOF: \_\_\_\_\_ (name) \_\_\_\_\_

DATE: \_\_\_\_\_ (signature) \_\_\_\_\_

F7441B: Level Change and Conversion Cases Notification Form

This form, indicating approval by a Placement Review Team of the Department's Case Management Screening Program, is required for any individual already residing in a Level II or Level III facility at time of application for MA or for a change in level of care if the facility is located in a city or town covered by CMSP.



*The Commonwealth of Massachusetts*

*Department of Public Welfare*

CASE MANAGEMENT SCREENING PROGRAM  
NOTIFICATION FORM

Level Change and Conversion Cases

Date: \_\_\_\_\_

In accordance with Department of Public Welfare regulations 106 CMR 456.201-456.204, the Placement Review Team of the Department's Case Management Screening Program has reviewed the case of (recipient's name) \_\_\_\_\_

Medicaid Number \_\_\_\_\_ and:

☐ Has approved the need for skilled nursing facility (Level II) services.

☐ Short term only. Re-evaluate in \_\_\_\_\_ months.

☐ Cannot approve the need for skilled nursing facility (Level II) services at this time because of the following reasons: \_\_\_\_\_

☐ Transfer required

☐ Transfer not required

☐ Has approved the need for intermediate care facility (Level III) services.

☐ Short term only. Re-evaluate in \_\_\_\_\_ months.

☐ Cannot approve the need for intermediate care facility (Level III) services at this time because of the following reasons: \_\_\_\_\_

☐ Transfer required

☐ Transfer not required

If the above-named applicant is located at a level of care different than the above determination, this patient will not be deemed eligible for Medicaid reimbursed long term care services unless it is indicated that transfer is not required. When transfer is required it is the responsibility of the facility to institute efforts to transfer the patient to the appropriate level of care or setting.

RIGHT TO APPEAL:

The General Laws provide that if you are not satisfied with any action by the Department of Public Welfare, you have the right to appeal and receive a fair hearing, before a referee of the Division of Hearings. The request for a fair hearing must be received by the Department within sixty (60) days of the date of this written notice to you of the decision of the Department's Placement Review Team. Attached please find the Department's request for a fair hearing form.

Placement Review Team Member: (name) \_\_\_\_\_

LOC: \_\_\_\_\_

(signature) \_\_\_\_\_

DATE: \_\_\_\_\_

(name) \_\_\_\_\_

LOP: \_\_\_\_\_

(signature) \_\_\_\_\_

DATE: \_\_\_\_\_

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

F7442: Sample Patient Care Referral Form

F7442

A form such as that below is required for any individual entering a Level II or Level III facility from any city or town not covered by the Case Management Screening Program. These cities and towns are listed in 7442.

MGH FORM 10617  
**PATIENT CARE REFERRAL FORM**  
**COMMUNITY AGENCY COPY**

M.G.H. Unit # \_\_\_\_\_  
 DATE of ADMISSION \_\_\_\_\_  
 DATE of DISCHARGE \_\_\_\_\_

Patient's Name \_\_\_\_\_ From: **MASSACHUSETTS GENERAL HOSPITAL**  
 Address \_\_\_\_\_ Unit or Clinic \_\_\_\_\_  
 Phone \_\_\_\_\_ Phone \_\_\_\_\_  
 Relative or Guardian \_\_\_\_\_ To \_\_\_\_\_  
 Address \_\_\_\_\_ Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Phone \_\_\_\_\_

Sex		Marital Status				Religion	Birthdate	Patient Knows Diagnosis	Yes	No
M	F	S	M	W	D	Sep.				
Medicaid No.		Blue Cross No.		Medicare No.		Plan		Family Knows Diagnosis	Yes	No
						A B		Which Family Member		

Diagnosis and/or Surgery Performed: \_\_\_\_\_

Important Medical Information (Allergies, Anticoagulants, Cortisone, Narcotics, etc.): \_\_\_\_\_

PHYSICIAN'S ORDERS:	Strength and Frequency	Last Dose Given	Stop Date	Begin Date
Medications				

Lab Tests: \_\_\_\_\_

Treatments: \_\_\_\_\_

Physical Therapy: \_\_\_\_\_

Precautions: Restrict Activity ☐ Yes ☐ No Sensation impaired ☐ Yes ☐ No  
 Weight bearing status ☐ Non-weight bearing ☐ Partial weight bearing ☐ Full weight bearing

Treatment: Frequency of visits \_\_\_\_\_ per week \_\_\_\_\_ per month  
 Exercises to \_\_\_\_\_ prevent deformity \_\_\_\_\_ motion regain \_\_\_\_\_ no increase angle of flexion  
 Gait training ☐ crutches ☐ canes ☐ braces ☐ prosthetic ☐ splints ☐ other \_\_\_\_\_

Other Services: ☐ Speech Therapy ☐ Occupational Therapy ☐ Homemaker Home Health Aid

Diet: ☐ Regular ☐ Therapeutic ☐ Tube Feeding

Goals: \_\_\_\_\_

MEDICARE CERTIFICATION FOR EXTENDED CARE: Patient, upon this patient's admission, is eligible for Medicare and has elected the options for which he received pre-qualifying investigation ☐ Yes ☐ No  
 Patient is currently homebound ☐ Yes ☐ No  
 Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_





7450: Home Care and Alternatives to Institutionalization

A Medicaid recipient who receives health care at home or uses the home as a base for medical care retains or regains independence, maintains a role as a functioning member of the community, and often convalesces more quickly than does an institutionalized recipient who has the same symptoms. In addition, care in a recipient's home is usually less costly than is care in an institution such as a long-term care facility or a chronic care hospital. Home care includes services offered through adult day health programs, psychiatric day treatment/day habilitation centers, private duty nurses, and home health agencies. A recipient may participate in one or in a combination of alternative services to fit his needs. Because alternative care allows the recipient to remain at home, the recipient may also take advantage of community resources such as sheltered workshops, senior citizen centers, social clubs or placement and training programs for additional support. (These services are not payable by Medical Assistance.) Care in the home is appropriate for those recipients who need intermittent skilled services or aide services and may be used for both recipients who have recently been institutionalized and for those who, without these back-up services, would have to be institutionalized to receive necessary care.

7451: Adult Day Health

Adult day health programs are structured environments in which a participant-client can receive health care in a social setting. The programs offer professional supervision, observation, and care in health, therapeutic, restorative and nutritional services as well as planned educational, recreational and social activities. Adult day health programs are available for non-General Relief Medicaid recipients who are 18 years of age or older and whose medical condition indicates a need for nursing supervision and services and possibly for therapeutic services. Transportation is arranged by the program and is reimbursable by Medicaid.

This type of service is available to recipients who:

- A. have been discharged from a hospital and need rehabilitation or nursing services as well as emotional support to promote their return to independent living;
- B. are at a risk of requiring long-term care facility placement because of medical or psycho-social conditions;
- C. have been discharged from a nursing home and who are able to return to their community through participation in a day-care program; and
- D. are chronically disabled and cannot be left alone without supervision.

7452: Adult Foster Care Program (see also 2127 and 6521)

Adult Foster Care (AFC) is a community-based program developed to serve individuals who are at risk of being institutionalized, that is, in need of 24-hour a day supervision and assistance in the activities of daily living. This program is designed to enhance the quality of life of its participants as well as to provide a less expensive alternative to institutionalized long-term care.



Prospective participants are persons currently residing in a nursing home or chronic hospital who it is believed would lead fuller and more normal lives in a family setting, persons on "administrative days" in an acute hospital who could be cared for in a private home with 24-hour supervision, or people in the community who are no longer able to live alone in their own homes. In order to retain a family-type atmosphere and to provide optimum individual care, each caretaker home is limited to two participants.

Each participant in the AFC Program must have been medically approved by his or her own primary care physician and determined to be an appropriate placement for foster care. Although the program was designed primarily to serve the frail and elderly population, any person over the age of 18 whose medical condition puts him or her at risk of institutionalization may be considered for adult foster care. There are currently 12 Medicaid-certified providers of adult foster care in Massachusetts.

Family Care Program Social Service Department  
Massachusetts General Hospital/Fruit Street  
Boston, MA 02114  
617-726-2640

Adult Foster Care Program/Elder Services of Merrimack Valley  
420 Common Street  
Lawrence, MA 01840  
617-683-0533

Montachussetts Home Care Corp./ Adult Foster Care Program  
545 Westminster Road  
Fitchburg, MA 01420  
617-345-7312

Old Colony Elder Services/Adult Foster Care Program  
231 Main Street  
Brockton, MA 02401  
617-584-1561

Roxbury Corp. Community Health Elderly Outreach Adult Foster Care  
435 Warren Street  
Roxbury, MA 02119  
617-442-7400

Tri-Valley Elder Services/Adult Foster Care Program  
284 Worcester Street  
P.O. Box 489  
Southbridge, MA 01550  
617-764-2501

Elder Services of Berkshire Co.  
100 North Street  
Pittsfield, MA 01201  
413-499-1353

Family Care Program of Cape Cod Hospital  
27 Park Street  
Hyannis, MA 02601  
617-771-1800 ext. 2405

Family Service Association of Greater Fall River  
101 Rock Street  
Fall River, MA 02720  
617-679-8200

Franklin County Home Care Adult Foster Care Program  
Central Street  
Turner Falls, MA 01367  
413-863-9565

Holyoke/Chicopee Regional Senior Service Adult Foster Care  
198 High Street  
Holyoke, MA 01040  
413-538-9020

Highland Valley Elder Services  
Adult Foster Care Program  
320 Riverside Drive  
Northampton, MA 01060  
413-586-2000

7453: Psychiatric Day Treatment/Day Habilitation Centers

A psychiatric day treatment/day habilitation center is a facility designed to serve clients (both recipients and non-recipients) who have mental illnesses, mental retardation, or emotional, developmental, or adaptive disorders. A recipient using this service needs more training or treatment than available through an hour's outpatient visit but does not need full-time hospitalization or institutionalization to become somewhat independent and to function within the community. A client typically attends 3 to 6 hours a day up to five days a week. He participates in a variety of activities such as individual and small group sessions, community meetings, pre-vocational counselling, family meetings, and goal-oriented social education. For admission, a physical (within six months) and a comprehensive evaluation concerning a client's mental status, medical status and needs, social skills, functional or developmental status and living and leisure capacities are required.

7454: Private Duty Nursing Services

A private duty nurse is either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) who is not related to the recipient and who provides the recipient with skilled nursing care in his or her home. A private duty nurse may be an individual practitioner who contracts with the recipient and with the Department before treatment can begin. Private Duty Nursing may also be provided through an authorized agency. Both individual and agency Private Duty Nursing require a Prior Authorization from the Department's Provider Relations Unit.

This service is appropriate for individuals whose medical needs cannot be met through a home health agency, a day-care program, or any other support programs available in his or her community and when the cost of such care is less expensive than is institutionalization.

7455: Home Health Services ..

Home health services are available for recipients in all categories of assistance while they are living outside of a hospital or a long-term-care facility.

A home health agency is a public or a private agency which provides nursing services, home health aide/homemaker services, and physical, occupational and speech therapies.

The home health program provides an alternative to institutionalization through a commitment to community-based support in the recipient's residence. Home health services are available when the patient's family or other concerned persons cannot furnish necessary professional care and when care in the home is less expensive than is care in an institution. It is frequently used for a limited time after a patient is discharged from a hospital, and needs temporary care at home.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

## 7456: Hospice Care Benefits

The only persons eligible under this program are people whose life expectancy is less than six months. They have made a decision to stop all curative medical treatments and receive only palliative care. This includes relieving pain, counseling, involvement with clergy if it is requested, and other measures that contribute to the comfort of the patient.

Because of the consequences of this decision, patients can and do change their minds. They can revoke the election of hospice care. A hospice case can be certified by Central Office Medicaid for two 90-day certification periods and as many 30-day extensions as the patient requests.

If you have direct contact with the patient, his family, friends, or both, please keep in mind the difficult decision the patient has made, and the vulnerability of all those involved.

### Your Responsibilities

When you are determining eligibility for Medicaid for a person who has elected Hospice Care:

- (1) obtain a copy of the election of hospice care from the appropriate hospice;
- (2) determine financial eligibility using only the patient's income and assets after the initial month of separation as defined in 505.450 (A)(2).
- (3) use the community standard to calculate the patient paid amount (PPA) including appropriate income disregards:
  - (a) compare the patient's net income to the federal poverty level income standard if it is higher than the MA income standard - if income is less than this amount there is no PPA - if income is higher, compare to MA income standard;
  - (b) compare the patient's income to the MA income standard - if income is less than this amount, there is no PPA - income in excess of this amount is paid to the hospice as a PPA;
- (4) complete the TD, entering Group code 4H in B1 23, the PPA, if any, in B1 26, and deduct code 7 or 8 in B1 27;
- (5) keep a tickler file for the 90-day period, and the subsequent ones as the recipient or hospice will provide a copy of each election;
- (6) complete the MA/NFL 3I, entering "0" for the amount of the PPA, if there is no PPA, and writing in the name of the hospice where it says "facility"; and
- (7) send the MA/NFL 3I to the recipient and the hospice.





7457: Massachusetts Rehabilitation Commission (MRC) Personal Care Attendant (PCA) Program Services

Benefits of the Medical Assistance Program are granted to persons, not otherwise eligible for Medical Assistance, if they are receiving personal care attendant (PCA) services provided by Massachusetts Rehabilitation Commission for at least fourteen hours per week. The purpose of the program is to allow handicapped people MA eligibility while they work in accordance with Chapter 118E, Section 1 of Massachusetts General Laws.

Potential recipients under this program must apply through their local area office of the Massachusetts Rehabilitation Commission. MRC determines eligibility for their personal care attendant services in accordance with 107 CMR 71.00 et seq. MRC will notify the Office of Assistance Payments when clients start to receive personal care attendant services and MA benefits are granted. Local welfare offices do not handle these cases.

7458: Personal Care Attendants Through the Independent Living Program

Independent living programs address the needs of persons with severe physical disabilities such as spinal cord injury (quadraplegics), muscular dystrophy, or multiple sclerosis. The purpose of these programs is to teach severely disabled persons to live more independently with the skills, training and other services of a personal care attendant.

Medical Assistance currently reimburses three operating independent living centers:

- A. Boston Center for Independent Living (617-536-2188);
- B. Worcester Alternative Transitional Housing (617-757-9435); and
- C. Southeast Independent Living (617-727-5048).

Similar programs are being developed in Lawrence and Amherst.

- D. Northeast Independent Living (617-727-5808, Lawrence);
- E. Stavros Foundation (413-256-0473, Amherst).

7458 (con't)

7450-5

Worcester and Boston have transitional housing programs that offer skills/training, PCA, and housing.

7459: Community ICF-MR'S

A Community ICF-MR is a residential treatment facility for persons who are mentally retarded or developmentally disabled. Each facility has from four to fifteen beds and is staffed to provide twenty-four hour care and supervision. The services provided include room and board; speech, physical, and occupational therapies; audiology services; medical and nursing services; psychological services; recreational and social services; training and habilitational services; food and nutrition services; and dental services.

Inquiries should be directed to the regional office of the Massachusetts Department of Mental Health.

7459.1 Renal Dialysis

Renal Dialysis provides outpatient treatment for patients with kidney failure.

A recipient who has end-stage kidney disease requires specialized treatment to maintain life; this treatment is either demodialysis or kidney transplant.

Because Medicare is the primary source of payment for persons under age 65 with chronic renal disease who need these types of treatment, recipients who may be eligible should apply for Medicare as soon as possible. Until Medicare coverage becomes effective (usually 90 days after application to Medicare), Medicaid will pay for dialysis services. Once a recipient is eligible for Medicare, Medicaid is responsible for payment of the Medicare co-insurance and deductible amounts. Medicaid also pays for transportation to the dialysis center.

7470: Services Covered by Medical AssistanceAbortion:

Recipients may obtain abortions through Medicaid when the attending physician certifies that it is necessary in light of all factors affecting the woman's health.

Artificial Limbs/Prosthetics:

Recipients may obtain prosthetics after they have been examined and have received a written recommendation from a hospital amputee clinic or a freestanding rehabilitation clinic approved by the Department. They will then be referred to a certified prosthetic company, which must receive prior authorization from the Department before purchase is allowed.

Braces/Orthotics:

Recipients may obtain orthotics when ordered by a physician when proven medically necessary and appropriate.

Dental Services:

Recipients may obtain emergency care, annual cleanings, X-rays, fillings, extractions, oral surgery and denture repairs. Children up to age 21 may receive, in addition, annual examinations, topical fluoride treatments, and stainless steel crowns. With prior authorization, recipients may receive root canals, crowns, full and partial dentures, gingivectomies, and elective oral surgery. Additionally, children may receive, with prior authorization, space maintenance, orthodontic treatment, and bridgeworks.

Durable Medical Equipment:

If living in their own home, recipients may obtain certain durable medical equipment (wheelchairs, hospital beds, crutches, canes, walkers, etc.) when ordered for them by a physician when proven to be medically necessary and appropriate.

Family Planning Services:

Recipients may obtain family planning counseling, birth control information, laboratory services, birth control devices and medications, venereal disease testing and treatment, cervical cancer screening, and breast examinations.

ORIGINAL ARTICLES

THE EFFECT OF VARIOUS FACTORS ON THE  
RESISTANCE OF THE HUMAN BODY TO  
INFECTION

BY DR. J. H. HARRIS, JR., CHICAGO, ILL.

It is well known that the human body is not equally resistant to all infections. The resistance is influenced by many factors, such as the nature of the infection, the state of the body, the age of the individual, and the environment. The purpose of this study is to determine the effect of various factors on the resistance of the human body to infection.

The study was conducted in a hospital where a large number of patients were treated. The patients were divided into two groups: one group was given a certain treatment, and the other group was given a different treatment. The results of the study are as follows:

1. The resistance of the human body to infection is influenced by the nature of the infection. The body is more resistant to certain infections than to others.

2. The resistance of the human body to infection is influenced by the state of the body. The body is more resistant to infection when it is in a healthy state than when it is in a diseased state.

3. The resistance of the human body to infection is influenced by the age of the individual. The body is more resistant to infection in the young than in the old.

4. The resistance of the human body to infection is influenced by the environment. The body is more resistant to infection in a clean environment than in a dirty environment.

These results show that the resistance of the human body to infection is influenced by many factors. It is important to know these factors in order to prevent infection and to treat it when it occurs.

7470 (con't)

Hearing Aids:

Recipients may obtain a new or replacement hearing aid after receiving an evaluation showing significant need from an ear specialist (otologist) or ear clinic, and from an audiologist in a Medicaid-certified hearing aid evaluation facility. They will then be referred to a hearing aid dealer who must obtain prior authorization for the purchase from Medicaid.

Hospital Services:

Recipients may obtain medically necessary inpatient hospital care and hospital out-patient services.

Laboratory Services:

Recipients may obtain laboratory tests when ordered for them by a physician.

Long-Term Care:

Recipients may obtain long-term care provided in nursing homes and chronic hospitals, when certified as medically necessary.

Medications/Drugs:

Recipients may obtain medications prescribed by a physician from their pharmacists.

Mental Health Services:

Recipients may obtain mental health services in mental health clinics, community health centers, general hospitals, and psychiatric day treatment centers. If the recipient is 65 or over, he may also obtain inpatient services in psychiatric hospitals. Recipients may obtain psychological testing services provided by a psychologist and any service provided by a psychiatrist.

Oxygen and Respiratory Services:

Recipients may obtain oxygen and respiratory devices (gaseous/liquid oxygen, humidifiers, suction machines, etc.) when ordered for them by a physician and proven to be medically necessary and appropriate.

Physician Services:

A recipient may obtain medical care provided by a physician.



7470 (con't)

Podiatry Services:

A recipient may obtain podiatry services to prevent and treat disease.

Project Good Health:

A recipient may obtain regular medical and dental screening, diagnosis, and treatment services from birth to 21 years of age.

Restorative Services:

A recipient may obtain physical, occupational, or speech therapy if to improve physical disability and when ordered by a physician. Services may be obtained from a private therapist or a freestanding rehabilitation center, or (for speech therapy only) at certain freestanding speech and hearing centers. Medicaid does not pay for diversional, recreational, or maintenance therapy.

766 Program:

The 766 Program ensures that those Medicaid-eligible children between the ages of 3 and 21 who are experiencing school-related problems can be provided with a special evaluation to identify the problem and determine the best way for their education to continue.

Speech and Hearing Clinics:

A recipient may obtain the services of a Medicaid-certified speech and hearing clinic when referred by a physician. However, if a hearing-aid evaluation is needed, he must first be evaluated by an otologist/otolaryngologist (ear specialist) or in an otology clinic at a hospital.

Sterilization:

A recipient may obtain a sterilization. A sterilization may be performed only if he signs the informed consent form (which physicians should have) at least 30 days before the operation. The recipient must be 18 years or older to obtain a sterilization.

Transportation:

Medicaid pays for transportation when you must travel to obtain necessary medical treatment, and when your condition requires a special type of transportation. (See Section 7200)

7470 (con't)

Vision Care:

Recipients may obtain eyeglasses if they have an eye examination and prescription by an optometrist or an ophthalmologist. Services are limited; recipients must ask their vision care provider about the limitations.



7500: PROVIDER REIMBURSEMENT PROCEDURES

When the Department does not pay a provider part or all of the amount billed, the provider is informed of the reason for this by means of a disallowance code on the Claims Remittance Advice. Certain of these disallowance codes result in an adjustment form being sent to the WSO/CSAO/LTCEU for approval or disapproval.

The form used by long-term-care facilities is the PA-9 adjustment form; that used by all other providers is the MCCC-1 form.

Since the provider has only 90 days from date of service in which to bill the Department, it is extremely important that the worker furnish the provider with the requested information as quickly as possible.

Providers are never to be given copies of the T.D. or of sections of the Recipient Master File. These contain confidential information for internal use only.

7510: PA-9 Adjustment Form

When the Department does not pay a long-term-care facility the full amount billed for a Medicaid patient, the facility is informed of the reason for this by means of a disallowance code on the Claims Remittance Advice. A table showing the meanings of these disallowance codes is provided for the workers information. Only certain codes, however, (G,I,J,K, and M) result in a PA-9 adjustment form being sent to the appropriate WSO/CSAO or LTCEU for approval or disapproval.

The date on which the form is received at the local office must be entered in block 41 of the PA-9 form.

7511: Review of Case Record

The worker reviews the recipient's case record in light of the disallowance code in block 39 of the PA-9. (If it is other than G,I,J,K, or M, the PA-9 is returned to the facility.) It must be determined whether the payment is actually owed to the facility by the Department and whether the information on the Recipient Master File correctly reflects the information in the case record. If the RMF is not correct, bills will continue to reject despite the worker's approval of the PA-9.

The mechanism to ensure that the information on a correct PA-9 and the information on the RMF are the same is Block 44 of the PA-9 Adjustment Form.

7512: Completing PA-9 Adjustment Form

The worker locates the TD on which the information in question was entered on the RMF (insurance, Block 31; later patient paid amount, block 26; code for long-term-care, Block 27 etc.), and records the preprinted number of that TD in Block 44 of the PA-9. If there is no TD with the correct and up-date information, a new TD must be generated and its number recorded in Block 44.

If the payment requested by the facility is approved, the worker enters the date of approval in block 42 and his signature (not just initials) in block 43.

If it is not approved, the form is returned to the provider with the necessary explanation or corrections (See below).

If it is approved for an amount different from that claimed in Block 38, this amount is entered in Block 46. "45" is left blank.





*The Commonwealth of Massachusetts*  
*Department of Public Welfare*

ALEXANDER E. SHARP, II  
COMMISSIONER

To: W.S.O./C.S.A.

Date:

From: Provider Name and Address

Provider No.:

RE: Disallowance Code M or 13, Ineligible Client for Dates of Service Billed

On the remittance advice with the check reference number \_\_\_\_\_ we received a Disallowance Code M or 13. We have rechecked our records and found the dates of service billed correspond to the dates that appear on the remittance advice. Please advise of the proper action.

Patient Name and Address

Cardholder No: \_\_\_\_\_

Suffix: \_\_\_\_\_

Category: \_\_\_\_\_

Dates of Service billed from: \_\_\_\_\_

To: \_\_\_\_\_

FOR DEPARTMENT USE ONLY

Provider Action: Take Action According To Checked Box

1. Client was not eligible on the dates of service. No payment can be made. ☐
2. Client was eligible only from \_\_\_\_\_ to \_\_\_\_\_ in your billing period. Submit a rebill only for these dates to the Medical Claims Control Center, Department 33. This authorization must be attached to your rebill. ☐
3. Client was eligible for the full billing period from \_\_\_\_\_ to \_\_\_\_\_. Submit a rebill to the Medical Claims Control Center, Department 33. This authorization must be attached to your rebill. ☐

W.S.O. Authorization: \_\_\_\_\_

Authorizing Signature: \_\_\_\_\_

W.S.O./C.S.A. Number: \_\_\_\_\_

W.S.O./C.S.A. Telephone Number: \_\_\_\_\_

FORM WSO/MCCC-1



7512 (con't)

When the PA-9 Adjustment Form and the TD if necessary, have been completed, the original PA-9 is sent to:

Medical Claims Control Center  
P.O. Box 567 Dept. 84  
Westboro, MA 01581

A copy is placed in the recipient's case record.

The disallowance codes and the necessary case actions are described below.

7513: Disallowance Codes Relevant for Local Offices

G. Medicare or Other Health Insurance Not Deducted

It insurance is coded in Block 31 of the most recent TD and the recipient is not currently covered by that insurance, a new TD must be generated changing Block 31 to the code for the proper insurance, or "z" for no insurance.

If the recipient does in fact carry the insurance, the policy number should be given to the facility. It may be necessary to contact a relative or to send a 1610 form to SSA in order to determine whether there actually is coverage.

I. To Be Paid By Recipient From Resources

If the latest TD reflects an amount in Block 26 greater than the recipient's current excess monthly income, a new TD must be generated.

If the recipient's income has increased and the increase was not turned over to the facility, the patient is responsible for making up the deficit.

J. Not Identifiable As Eligible Card Holder

The facility may have reversed digits of the SSN or may have billed the wrong category. The worker makes the necessary corrections on the PA-9 and returns it to the facility.

Often this code appears on a PA-9 for an SSI Rest Home patient (Level IV) who has never been entered on the RMF. Receipt of SSI must be verified and the case entered on category 03 or 01 on the Master File "3C" must be entered in Block 23 of the TD.

7513 (con't)

K. Person Not Included In Card Holder Family

This would be a category 06 or 08 case. It is necessary to check the case SSN and the dependent's suffix number to be sure the information on the PA-9 is the same as that on the RMF.

M. Ineligible Patient For Date Billed

If the recipient was eligible for Medicaid for the dates billed, block 17 of the TD will reflect this. He may not have been coded for long-term-care on the same TD that established the case on the RMF, however. Excess assets may have been used to pay the L.T.C. facility the first month, or a specific number of days of the first month of eligibility. Once that payment was made, the recipient would be eligible for medical bills other than the daily rate at the facility. A second TD, therefore, would establish the patient paid amount when he became eligible for L.T.C. payment. If a bill is disallowed because the case is not coded for long-term-care, the worker must determine whether the omission was intentional before approving the PA-9.

There are times when a patient enters a L.T.C. facility in the middle of a month having already spent his monthly income on rent, utilities etc. The worker makes out two TD's, the first with no P.P.A. for the partial month, and the second with the regular ongoing P.P.A. effective the following month. If the bill for the partial month is not submitted right away, the Department may deduct the P.N.A. from it as well. The worker must be sure to enter the number of the first TD (with the zeroes in Block 26) in order for the facility to receive full payment for this period of time.

7514: Complete Table of Disallowance CodesCODE REASON

- A. Rate in excess of fee schedule.
- B. Service is not an approved item.
- C. Provider error in computation.
- D. First and last days of service counted as one day.
- E. Request for Prior Approval is Modified, Disapproved, Incomplete or Missing.
- F. Medical Report Incomplete or not received to Authorize payment.

7520: MCCC-1 Form

When the Department does not pay a Medicaid provider, other than a long-term-care facility, for a service billed, the provider is also informed of the reason by means of a disallowance code. Only Code M (or 13), however, results in an adjustment form, the MCCC-1 being sent to the local office for approval or disapproval.

7521: Review of Information

The worker checks the MCCC-1 for accuracy of the SSN, the suffix and the category. Often the problem is in this area because the provider has taken the information from previous records in his office rather than from the current MA/ID card.

If an individual has been eligible for MA more than once, it is entirely possible that his Medicaid billing number has changed, sometimes several times. A child may at one time be covered on category 08 under his father's SSN and at another time on category 02 under his mother's SSN, or on category 03 under his own SSN.

The 19-digit number used by the provider must be the correct number for the particular date of service; otherwise the bill is rejected.

If the worker finds that the start date on the RMF is incorrect, a new ID is generated to correct it.

7522: Completion of MCCC-1 Form

The lower half of the MCCC-1 is completed in the following manner.

If the recipient was not eligible during any part of the service period under any billing number, the worker checks the first block.

If the recipient was eligible for part of the billing period, the worker corrects the billing number if necessary and checks the second block, filling in the dates of eligibility.

If the recipient was eligible on the date(s) of service on the MCCC-1, the worker makes the necessary correction in the billing number and checks the third block, filling in the dates as stated by the provider above.



7522 (con't)

The remainder of the MCC-1 is completed as follows:

WSO Authorization	(Name of AO/BO)
Authorizing Signature	(Worker completing form signs and adds date of approval).
AO/BO Number	(3 digit AC/BO number)
AO/BO Telephone Number	Number where worker can be reached.

The original is returned to the provider to be attached to the resubmitted bill. A copy is placed in the case record.

PA-9 ADJUSTMENT

PA-9 A0J 3-74



7530: Authorization of a Special Services Vendor Payment

A worker authorizes vendor payment for certain services e.g. medical transportation by completing an Invoice for Special Services. Instructions for the completion of the Invoice for Special Services and the applicable procedure codes are found in the Systems Manual.

NOTE: The Invoice for Special Services replaces the PA-33A. If the Worker finds reference to the use of the PA-33A elsewhere in this Handbook, (s)he will now use the Invoice for Special Services.





7580: Long Term Care Patient Paid Amount Discrepancy Report:

Long term care facilities submit bills monthly for services provided to MA recipients in their care. Since they bill at a per diem rate, it is possible to predict the amount each facility will bill for each recipient.

When a facility submits a claim for an amount that is less than the anticipated amount, MMIS will process the claim and report the Recipient Identification Number (RID) on an R216 (Long Term Care Patient Paid Amount Discrepancy Report).

The R216 indicates that the recipient's payment to the facility has increased. This usually indicates an increase in the recipient's income.

When a worker receives a PPA Discrepancy Report, and the change in the recipient's circumstances is not already known to him, he must contact the recipient, his representative, or the facility to determine what change in income caused the reduced claim. If the recipient's income has increased, the worker must verify the new amount and complete a PI-1, T.D., and Long Term Care Source Document changing the PPA, repeating the deduct code, and indicating the effective date of the change (See MA Handbook Handbook M200). The T.D. and the LTCSD must be given to the Data Entry Clerk simultaneously.



7590: Long Term Care Suspense Report (Suspended Claims)

Claims submitted to MMIS for payment of long term care services must contain the provider's identification number and the level of care at which services were provided during the billed dates of services. For the claim to be paid by MMIS, the MMIS Recipient File must contain the authorized provider's identification number and the same approved level of care for the same dates of service. These data elements are obtained from the CMSP Form and/or the SC-1 Form and are entered on the FMCS and MMIS Recipient Files by submission of a T.D. and/or LTCSD.

If a discrepancy exists between the information on the claim and the information on the MMIS Recipient File, the claim is suspended (i.e., payment is not made) and the discrep~~ant~~ant information is reported on the Long Term Care Suspense Report (LTCSR) for action by the LTCU/CSAO/WSO responsible for the recipient's case. The suspended claim is recycled every 15 days for a period of 60 days awaiting correction to the MMIS Recipient File.



7600: Kaileigh Mulligan Home Care for Disabled Children ProgramDescription of Program

The Kaileigh Mulligan Home Care for Disabled Children Program is a Medicaid program designed to allow certain severely disabled children who meet the criteria described in Section 507.200 of the Medicaid Manual to live at home and receive Medicaid without counting the income and assets of the child's parents. Note that the child may not have income more than the sum of \$20 plus the Department's current personal needs allowance, and assets cannot exceed the SSI asset standard for one.

A brochure and fact sheet have been developed to assist you in responding to inquiries about the program. Specific questions or concerns about a child's eligibility for the Kaileigh Mulligan Program should be directed to the Kaileigh Mulligan Unit at Central Office.

Assess Financial Eligibility

To begin the eligibility process, the family must complete a Medicaid application. Because the program is for the child, only the child needs to meet basic and financial requirements, which must be verified.

FIRST, REVIEW THE PARENT'S DECLARED INCOME AND ASSETS AS LISTED ON THE MEDICAID APPLICATION WITHOUT REQUESTING VERIFICATIONS.

- If the parents' income and assets are over the standards for MA Under 21 and MA/DA, review the child's income and assets. If the child meets the program limits, refer the case to the Kaileigh Mulligan Program Unit using the HCDC-1 (Applicant Referral Form). The parents do not need to complete the Disability Supplement for Children.
- If the parents' income and assets are close to the MA-Under-21 limits, request verifications from the parents and determine the child's eligibility for MA Under 21.

If there is a spenddown, the parents may want to access Medicaid for their disabled child by meeting it. (If not, refer the case to the program unit.) If the child is later determined to be eligible for MA/DA without a spenddown, or for the Kaileigh Mulligan Program, the bills used to meet the spenddown could be paid by Medicaid.

- If the parents' income and assets are under the MA/DA limits, process as an MA/DA application. Have the parents submit verifications and complete the Disability Supplement for Children. Send the supplement to DDU. (Do not refer the case to the program unit.)



Kaileigh Mulligan Program Eligibility

For each case referred to the Kaileigh Mulligan Program Unit, the program unit will determine the child's medical eligibility. Keep this case pending until the program unit informs you of the child's eligibility. The program unit will send you a copy of the eligibility determination letter sent to the parents of each applicant. A denial or approval letter for the Kaileigh Mulligan Program is a denial or approval for Medicaid.

- If the child is eligible for the program, establish the case on category 7, budget group code 4D.
- If the child is not eligible, but is disabled, be sure the parents are informed of the relative advantages of MA/DA with a spenddown and the CommonHealth Disabled Child program with a premium. Keep in mind the medical services that the child requires.

If the parents choose MA/DA, determine the child's eligibility by requesting income and assets verifications (if not previously requested) and using the SSI-related income disregards. If the parents opt for CommonHealth, refer the case to CommonHealth.

- If the child is not eligible and is not disabled, determine eligibility for MA Under 21. Request verifications if not previously requested.

If you determine that the child is eligible for MA/DA or MA Under 21, send an approval letter. However, if the child is not eligible for either program, you do not need to send another denial letter.

Financial Redetermination

You are responsible for redetermining the child's financial eligibility for the Kaileigh Mulligan Program every six months. These cases will appear on the PAL with a special message. Only the disabled child's income and assets need to be considered in redetermining financial eligibility.

IF THE CASE BECOMES INELIGIBLE FOR ANY REASON OTHER THAN DEATH OR RELOCATION TO ANOTHER STATE, CALL THE POLICY HOTLINE BEFORE TAKING ANY ACTION TO CLOSE THE CASE.

Medical Redetermination

The Kaileigh Mulligan Program Unit reviews the child's medical eligibility annually. If the child no longer meets the program's criteria, the program unit will send you a copy of the letter sent to the family indicating the child's ineligibility for the program. You should then redetermine for further eligibility (i.e., CommonHealth, MA/DA, MA Under 21), using the guidelines noted above.



To: Kaileigh Mulligan Program Unit

From: \_\_\_\_\_, Medicaid Worker  
\_\_\_\_\_, Local Office  
\_\_\_\_\_, Address  
\_\_\_\_\_, City/ZIP  
( ) \_\_\_\_\_ Phone  
(include Speed Number)

Date:

Re: Kaileigh Mulligan Program Applicant Referral

I am referring the following child to you for a determination of Medicaid eligibility under the Kaileigh Mulligan Home Care for Disabled Children Program.

I have determined that the child meets the basic requirements and Kaileigh Mulligan Program's income and asset criteria.

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/ZIP: \_\_\_\_\_

Phone: Home ( ) Work ( )



7750: Emergency and Pregnancy-Related Services for Aliens

**Introduction** Certain aliens who are not otherwise eligible for Medicaid may be eligible for emergency and pregnancy-related services in accordance with 106 CMR 507.320 and 507.600 of the Medicaid Policy Manual. These services are available to persons granted lawful temporary or lawful permanent resident status and to undocumented aliens. Aliens admitted for a temporary purpose such as students, visitors, and diplomats are not eligible for these services.

A. Pregnancy-Related Services

**Who is eligible?** Pregnant women may be eligible for payment of pregnancy-related services if they have been granted:

- lawful temporary resident status; or
- lawful permanent resident status.

**What services?** Pregnancy-related services are prenatal care, labor and delivery, and routine 60-day postpartum care. (Pregnant women are also entitled to emergency medical services, as described in Section 7750 B.)

**How verified?** This status is verified by a unique I.D. card, I-688 or I-688A issued by the Immigration and Naturalization Service (INS). The card will state that the individual is not eligible for medical assistance for five years.

**How eligible?** These women must meet all other basic and financial eligibility criteria, including eligibility under the spenddown provisions.

**How to put on PACES TD?** Once a woman meets the basic and categorical eligibility criteria, complete PACES TD:

- category 6;
- action reason 09 in blocks 33 and 89; and
- group code 1F in block 35.

See PACES User's Guide for complete instructions on establishing case on PACES.

**What verifies eligibility?** PACES sends an approval letter that will serve as verification of her entitlement to pregnancy-related and emergency services only.

**How do providers verify eligibility?** Providers are instructed to call the local office to verify an alien's current eligibility.



When should case be re-determined? Redetermine continued eligibility after the birth of the child. If five years have passed since the woman was granted lawful temporary resident status, she may be eligible for Medicaid. If the five-year period has not elapsed, she may be eligible for emergency services, as described in Section 7750 B.

What if eligible for Medicaid or emergency services? If the woman is eligible for either Medicaid or emergency services, you must close the category 6, action reason 09 case and reopen it using the new action reason (02 for Medicaid or 04 for emergency services only).

Since the child was born in the United States, he or she is an American citizen. Therefore, also review the child's Medicaid eligibility at that time.

## B. Emergency Services

Who is eligible? Aliens who meet the eligibility criteria for Medicaid, except for furnishing or applying for a social security number and meeting the citizenship and alienage requirements, are eligible for payment for emergency medical services only.

These aliens may be:

- undocumented aliens; or
- members of an amnesty group whose status is verified by an I-688 or I-688A card, as described in Section 7750 A.

What about SSNs? If an alien does not have a social security number, provide him or her with a unique facsimile number. If an alien is currently receiving General Relief and has a unique facsimile number, use the same facsimile number to establish the case for emergency services.

How to put on PACES TD? Once an alien meets the applicable basic and categorical eligibility requirements, complete PACES TD:

- If the applicant is an undocumented alien who is pregnant:
  - enter as a category 6;
  - action reason 09 in blocks 33 and 89; and
  - group code 1G in block 35.
 These aliens are eligible for emergency services including payment of labor and delivery costs.



- If the applicant is not pregnant and is an undocumented alien or a member of an amnesty group:
  - enter appropriate category (5-8);
  - action reason 04 in blocks 33 and 89; and
  - either group code 1H (community) or group codes 3D - 3Z (LTC) in block 35.

The alien is eligible for emergency medical services only.

See PACES User's Guide for complete instructions on establishing case on PACES.

What verifies eligibility?	PACES sends an approval letter that will serve as verification of his or her entitlement to emergency services only, including labor and delivery, if applicable.
How do providers verify eligibility?	Providers are instructed to call the local office to verify an alien's current eligibility.
When should case be re-determined?	If client is pregnant, redetermine continued eligibility after the birth of the child. Redetermine all other cases every six months as you would any other Medicaid case.

#### C. Client Notification

When to send manual notice?	If the case is denied for basic or categorical reasons, send an MA-NFL-5.
What does PACES do?	PACES will do all financial eligibility determinations and send the appropriate approval or spenddown notice.
How to close case?	When closing these cases, use the same closing action reasons used for all other Medicaid cases. PACES will generate an automated closing notice.



7800: Qualified Medicare BeneficiariesIntroduction

The Medicare Catastrophic Coverage Act of 1988 requires that Medicaid pay the premiums, coinsurance, and deductibles of certain Medicare recipients. Such individuals are referred to as qualified Medicare beneficiaries (QMBs). Many MA recipients will be eligible as QMB's. For them, the primary benefit is that Medicaid will pay their Medicare Part B premium. As a result, the amount of the beneficiary's monthly railroad retirement or social security benefit will increase. Persons who are over the MA asset standard but under the QMB asset limit will be entitled only to payment of Medicare-reimbursable services and premiums.

Note: If your client is a former SSI recipient, always determine his or her potential eligibility as a Pickle first. If eligible, he or she will automatically be eligible for the Medicare buy-in.

Who is Eligible?

To be eligible for QMB status, an applicant must:

- o meet the basic requirements for Medicaid (e.g., residency, citizenship);
- o have assets less than \$4,000 for an individual, \$6,000 for a couple (twice the SSI asset limits); and
- o have income less than or equal to 100% of the federal poverty level income standards. The income spenddown provision does not apply to QMB.
- o be entitled to Medicare Part A. Persons who receive Part A at no cost to them include those who (1) receive RSDI benefits and are age 65 or over; or (2) have been disabled for two years or more; or (3) have received dialysis or renal transplantation for three months.

Persons eligible to purchase Part A are those who are age 65 or over and are either a U.S. citizen or have been a resident alien for five years or more and who are not entitled to free Part A as described above.

How Do Individuals Apply?

Current Medicaid recipients do not need to apply for QMB. (See "Ongoing Recipients" section.) However, you must determine their eligibility for QMB benefits at redetermination or when they request a QMB eligibility determination.

Applicants for QMB must complete a Medicaid application. Remember to give the applicant the QMB cover letter, the "Notice to Persons Asked to Furnish Social Security Numbers" (NTP), and the Assignment of Rights (A-34/36).

Procedures for Determining Eligibility - New Applicants

An applicant can be both Medicaid and QMB eligible. However, applicants have the right to apply for just QMB status. Determine eligibility for both programs, unless the applicant has asked to apply only for QMB. QMB benefits eligibility is applicable to both community and long-term-care cases.

- o Be sure the applicant has submitted proof of eligibility for or receipt of Medicare Part A. For persons who already receive Part A, acceptable verification is a copy of their Medicare card; any evidence from a prior Department record of receipt of Part A; or use of TPQY.

Persons eligible to purchase Part A must get a statement to that effect from the Social Security Administration.

- o Determine the applicant's financial eligibility for QMB status using the SSI-related income deductions. Remember to use the gross monthly social security or railroad retirement amount in making the eligibility determination. (Add the amount of the current Part B premium if only the net amount is known.) The income spenddown provisions do not apply and health insurance premiums are not deductible.
- o If the assets are less than the applicable standard and net countable income is less than or equal to 100% of the federal poverty level, the individual is eligible as a QMB.

Example 1 - Community Case

Quentin M. Barnes receives \$370 per month in social security disability after his Part B premium deduction. In addition, he works part-time for an answering service and earns \$80 gross per week. He also has \$1800 in the bank. Mr. Barnes is entitled to both Medicare Part A and B. Is Mr. Barnes eligible for Medicaid, QMB, or both?

Medicaid Eligibility

Unearned:  $\$370 - \$20 = \$350$

Earned:  $\$80 \times 4.333 = \$346.64$   
 $\$346.64 - \$65 = \$281.64$   
 $\$281.64 \div 2 = \$140.82$

Total Income:  $\$140.82 + \$350 = \$490.82$

Mr. Barnes is eligible for Medicaid because his net income (\$490.82) is below the federal poverty level income standard for one (\$498), and his assets (\$1800) are below the Medicaid asset standard for one (\$2000).







Medicaid Eligibility

Unearned Income:  $\$100 + 350 = 450$   
 $450 - 20 = \$430$

Assets:  $\$2500 + 1300 = 3800$   
 $- 2000 \text{ MA asset limit}$   
 -----  
 $\$1800$

Ms. Bismaick is not eligible for Medicaid since her assets exceed the MA asset limit.

QMB Eligibility

Unearned:  $\$100 + 350 + 32 = 482$   
 $482 - 20 = \$462$

Ms. Bismaick is QMB eligible since her income is less than the federal poverty level income standard for one (\$498) and her assets are less than the QMB asset standard for one (\$4000).

Notification

QMB eligibility begins the first day of the calendar month after the month in which eligibility is determined.

Notification depends on whether the applicant is eligible for both or only one of the benefits and on whether the applicant has applied for both programs. Use the following guidelines to determine which notification letters you should be sending.

IF the individual applied for Medicaid and is .....	THEN send .....
Eligible for MA <u>and</u> QMB,	QMB approval (QMB-1) and the appropriate MA approval
Categorically ineligible for MA and QMB	MA/NFL-5
Financially ineligible for MA and QMB	MA/NFL-8A + MA/NFL-5
QMB eligible and MA ineligible	QMB-1 + MA/NFL-8A
QMB ineligible (not entitled to Part A) and MA eligible	MA Approval

IF the individual applied only for QMB and is .....	THEN send .....
Eligible	QMB-1
Ineligible	MA/NFL-5

These notices will be automated with the implementation of PACES.

QMB recipients will be notified by the Social Security Administration when their Medicare buy-in is effective. Individuals who currently pay Part B premiums will receive an increase in their social security or railroad retirement checks because this premium will no longer be deducted from their checks. They will also receive a retroactive payment representing the number of months they paid their Medicare Part B premiums after their eligibility as a QMB was established. (It will take approximately three months for this to happen). The check increase will have no affect on community cases since you used the gross social security amount in determining eligibility. If the individual is in a long-term-care facility, however, you must adjust the patient paid amount to reflect the new social security amount.

#### Ongoing Recipients

Review a recipient's potential eligibility for QMB status if he or she inquires about the program. Otherwise, at redetermination, review a recipient's potential eligibility for both Pickle and QMB. If your client is eligible for QMB, send the QMB approval letter.

#### Establishing the Case on the System

QMB cases are established on the system the same way as any other Medicaid case except that specific action reasons must be used to designate whether a recipient is eligible for Medicaid benefits, QMB benefits or both. The correct use of action reason is important because it tells the system when to begin paying a recipient's Medicare premiums.

#### Person is eligible for Medicaid and QMB: New and Reopened Cases

When an individual is eligible for both Medicaid and as a QMB, establish the case on category 5 or 7 with action reason 12.

#### Ongoing Cases

If, as the result of a redetermination, a Medicaid recipient is found to be also eligible as a QMB, change the action reason to 12.

Persons eligible as QMB only

Because Medicaid services for QMB only cases are limited to Medicare covered services, special steps must be taken in opening and closing a QMB only case.

When an individual is eligible only as a QMB, establish the case on category 5 or 7 with action reason 15. Action reason 15 is used by MMIS and the MassHealth Card systems to restrict Medicaid services to only Medicare covered items and services.

Changes in Eligibility

If, as a result of a change in circumstances (e.g. reduction in assets), the individual later becomes Medicaid eligible, the QMB only case must be closed and then the case reopened with the appropriate Medicaid action reason code, i.e. 01, 12 or 13. Eligibility may begin as early as the 1st of the preceding third month if the person was eligible.

If a Medicaid recipient becomes ineligible for Medicaid but would still be eligible as a QMB only, the Medicaid case must be closed for the applicable reason and the case then reopened with action reason 15. The medical start date will be the day following the MA termination.

In order to assure proper tracking of these cases, when there is a change in an individual's eligibility, you may not simply change the action reason on an active case to 15 or from 15 to another action reason. An edit in the system will prevent this.

Whenever an action reason is used that will effect payment of an individual's Medicare premium, the recipient's Medicare claim number, including the alpha or alpha-numeric claim suffix, must be entered on the system.

If an individual is eligible to purchase Medicare Part A, (i.e. the person is 65 or over and either a U.S. citizen or a resident alien for five years or more), a "K" must be entered in the health insurance field of the TD. This code may be changed once the Medicare becomes effective.

Complete the appropriate TPL documents to note additional health insurance coverage as you do for all other new applicants.

MassHealth Card

All eligible recipients will receive a MassHealth card reflecting their QMB and/or Medicaid status. Recipients who are QMB-only may be issued a temporary card only as a replacement for a MassHealth card. (New QMB only cases should not need a card since QMB eligibility will not begin until the first day of the subsequent calendar month.) Be sure the following message is entered on the QMB only temporary card: "Restricted to Medicare-covered services."



7810: Qualified Disabled Working IndividualsIntroduction

Under the Omnibus Budget Reconciliation Act of 1989, Medicaid is required to pay the Medicare Part A premium for certain disabled working individuals, in accordance with 106 CMR 507.520 of the Medical Assistance Policy Manual. These individuals are former RSDI recipients who lost Medicare Part A as a result of losing their entitlement to the cash benefit, and who meet certain conditions. The Social Security Administration will contact people who lose Medicare due to employment and advise them of their potential eligibility for this benefit.

Eligibility Requirements

To be eligible for this benefit, the following conditions must be met:

- o the individual must be under age 65;
- o the individual must have lost or is losing Medicare Part A only because he or she is working;
- o the individual is entitled to enroll in Medicare Part A (hospital insurance benefits) under Title XVIII, section 1818A of the Social Security Act;
- o the individual's countable assets do not exceed \$4,000 for an individual or \$6,000 for a couple;
- o the individual's net income does not exceed 200% of the federal-poverty-level income standards in accordance with 106 CMR 506.430; and
- o the individual is not otherwise eligible for Medicaid.

Establishing the Case

1. Have the individual complete and sign a Medicaid application (MA-3).
  - o If the individual is already enrolled in Medicare Part A, eligibility for buy-in is established three months prior to the month of application for the buy-in.
  - o If the individual is not already enrolled in Medicare Part A, eligibility for buy-in is effective when he or she enrolls.
2. Complete a PACES Worksheet and TD. (See the PACES User's Guide for complete instructions on establishing a case on PACES.)
  - o Category 7
  - o Group code 4R
  - o AR 16 - Blocks 33 and 96
  - o Enter valid Medicare claim number and health insurance code on TD.

PACES will establish eligibility or noneligibility and send the appropriate notice.

3. These cases will appear on the Daily Caseload Report (DCR) as approved, denied, or terminated.
4. These cases will be subject to the normal redetermination process on PAL.
5. The individuals are not eligible for Medicaid and, therefore, will not receive a MassHealth card or be entered on MMIS.





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CHAPTER EIGHT - PICKLE CASES8000 BACKGROUND

In April 1977 an amendment to the Social Security Act was passed with the objective of preventing SSI recipients from losing their automatic medical coverage because of the yearly cost-of-living adjustments in their Social Security benefits. The amendment was introduced by Representative Pickle of Texas, and cases protected by this amendment have come to be known as "Pickle Cases".

Under this provision an individual who received both SSI and SSA benefits in the same month at any time after April, 1977 is eligible for MA benefits without a spenddown, provided he still receives SSA benefits and would currently be eligible for SSI but for the cost-of-living increases in his SSA benefits since the last month in which he was eligible for and received SSI.

8010: Revision of Policy: Ciampa v. Schweiker

The Pickle Amendment was originally interpreted to mean that only those individuals who become ineligible for SSI immediately upon the receipt of the Social Security cost of living increase were automatically eligible for continued medical assistance. However, a court suit, Ciampa v. Schweiker was brought against the Department and the Department of Health and Human Services (H.H.S.) The court ruled that the Pickle Amendment requires that Pickle eligibility applies to individuals and/or their spouses, if any who:

- A. were eligible for and received both SSI and RSDI benefits in some month after April, 1977, and
- B. are currently receiving RSDI benefits but are currently ineligible for SSI benefits, and
- C. would still be eligible for SSI upon deducting from income all RSDI cost-of-living increases received: 1. by the individual subsequent to the last month, after April, 1977 during which the individual was eligible for and received both RSDI and SSI benefits, and/or 2. by the individual's spouse subsequent to the last month after April, 1977 during which the spouse was eligible for and received both RSDI and SSI benefits.

As a result of the court's decision, the method of determining eligibility for Pickle status was revised. The revised method of calculation is described in 8400.

The worker needs to be aware that many cases not originally considered eligible under the Pickle Amendment because the termination from SSI was due to a change in living arrangements or receipt of other benefits, such as Veteran's benefits or private pensions, should have been eligible, or may still become eligible for Pickle status in the future. This is because the countable amount of their Social Security benefit is fixed at the amount received for the last month in which the individual and/or spouse was eligible for and received SSI benefits, while the SSI payment standards are increased each year.

It is fairly safe to assume that almost any person terminated from SSI by reason of excess income will eventually become eligible for MA without a spenddown as a Pickle case unless he dies or enters a long term care facility.

Pickle cases must continue to meet SSI categorical requirements. Financial eligibility is also determined according to SSI standards for income and assets.

8200 IDENTIFYING PICKLE CASES

As a result of the Ciampi v. Schweiker decision every SSI-related applicant or recipient who received SSI cash assistance in any month after April 1977 must be considered for possible eligibility under the Pickle Amendment at each application/redetermination.

If a worker in determining eligibility according to 8300 and 8400 needs assistance in obtaining or interpreting an SDX document, the person designated by the Director should call the SSI Unit at Central Office (727-8562).

If he needs assistance in making a determination of Pickle Eligibility for a disabled child, a couple with only one member categorically related to SSI, or any other situation not covered in this chapter, a memo giving the facts of the case should be sent to:

Department of Public Welfare  
Central Services, SSI Unit, 5th Floor  
600 Washington St.  
Boston, MA 02111

Once an individual is determined to be eligible for automatic medical assistance under the Pickle Amendment, the case is identified as a Pickle by entering the code "13" in Block 19 of the Turnaround Document.

The validity of this "13" code must be reviewed at each redetermination and changed to an "02" when necessary as almost any change either in the recipient's circumstances or in the SSI payment standards can affect Pickle Status.  
(See 8419)



8210: Pickle Lists

Most Pickle cases are first identified by the Social Security Administration. Each year a list of cases terminated on SSI because of the Social Security cost of living adjustment is given to the SSI Unit at Central Office. After the Department announces the SSI cost of living increase, some of these individuals become eligible again for SSI, and a new Pickle List is created comprising only those whose SSI cases remain closed. This "net" Pickle List is broken down by WSO and sent to the local offices.

These cases continue to receive Medicaid cards on category 1 or 3 until instructions are sent to the field for converting them to category 5 or 7 with an Action Reason 13. At the same time procedures are issued for determining their eligibility for Pickle status. Those determined to be eligible for Pickle status retain the Action Code 13 and are kept on the State Buy-In List for Medicare B.

When a case is determined to be eligible as a Pickle, an NFL-3 is sent to the recipient stating that eligibility has been approved "in accordance with the provisions of the Pickle Amendment."

The case is filed with other Pickle cases.

Cases that are no longer eligible for Pickle status are then determined for eligibility as regular MA cases. At the time of the next redetermination they must again be considered for Pickle eligibility, as an SSI cost of living increase in the meantime may render them eligible again.

T-8210: Procedures for Handling the 1984 Pickle List

During the month of January, advance copies of the 1984 "Pickle List" were distributed to local offices. These lists include only individuals terminated from SSI due to the 1984 SSA cost-of-living adjustment and kept open on the Recipient Master File as category 1 or 3 until 2/29/84. Each case has now been (re)opened on category 5 or 7 effective 1/1/84 to protect medical benefits until eligibility for Pickle status can be determined. T.D.s reflecting this change were generated and sent to local offices during the week of February 20. These cases can be identified by an Action Reason 13 and Worker #972 in block 91. Pickle cases are priority redeterminations in March and April and they should be processed in the order returned.

For each case on the Pickle List for which he is responsible, the worker will receive an SDX Document dated 11/19/83. Transaction code "J" will be in POS. 7 of block 1.

The worker must mail a redetermination form with the green redetermination cover letter and the Notice to Former Recipients of SSI (AP/ADM-84-10 Attachment A). MA redetermination forms to determine Pickle eligibility may be mailed at any time after this MA-TN is received. They must all be mailed by 3/15/84. The date entered on the second line of the letter should be 30 days from the date of mailing, that is, not later than 4/16/84.

When sending the redetermination letter, the worker should add the date "1/1/84" after "checking statements since last redetermination" in Section 6-9 of the List of Verifications. (This is the date of termination of SSI benefits.)

When returned, the form will be used first to determine eligibility for Pickle status and second (if not eligible for Pickle) to determine eligibility for regular MA.

Determination of Eligibility for Pickle Status

If the redetermination is not returned, or a reasonable explanation for its delay is not received in writing by April 16, action must be initiated to close the case.

Eligibility for Pickle status is determined according to Chapter 8. The amount of Social Security to be used in determining Pickle eligibility is the December 1983 amount from the SDX Document dated 11/19/83 or the Old OASDI (RSDI) amount from the Pickle Listing.

The amount(s) and type(s) of unearned income (blocks 60-65) and gross earned income (blocks 67-68A) from the SDX Document dated 11/19/83 should be used only as an indication of types of income received by the recipient. Refer to the SDX Reference Guide for an explanation of the codes. Current receipt and amount of all income must be verified.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

8210

Buy-in of Medicare B is automatically continued for all Pickle cases. If an eligible recipient is paying his own premium, follow instructions in T-8231 to add him to the Department's Buy-In List. If the individual is eligible as a Pickle case, an MA/NFL-3 should be sent stating that eligibility has been approved "in accordance with the provisions of the Pickle Amendment." The disposition block on the redetermination form is coded "P," indicating eligibility for Pickle status. The redetermination log is also marked with a "P" for Ciampa compliance.

If the recipient is no longer eligible under the Pickle Amendment, the worker must submit the case to his supervisor for a second-level review. If the supervisor concurs, the special Ciampa denial letter (Attachment B of T-8230) must be sent with the NFL-1. Eligibility must then be determined for MA as for any MA-only case. This will usually result in a spenddown case. If it does, an MA/NFL-8R must be sent with the Ciampa denial letter and the MA category 5 or 7 case must be closed. The disposition block on the application is coded "NP" indicating that the case is not now eligible for Pickle status but must be considered for Pickle status again if the spenddown is met and the case is subsequently redetermined.

8220: Former SSI Recipient Applies For MA

Often recipients who have recently been terminated from SSI inquire about Medical Assistance before the Pickle Lists are compiled. When this happens:

- A. If the individual is still receiving MA/ID cards and still appears in open status on category 01 or 03 on the RMF, inform him that no action is necessary unless he receives a termination notice from the Department.
- B. If he has been terminated by the Department as well as SSI (closed status on the RMF), suggest that he file an application for MA.



VOID - MA - Transmittal Notice No. 5.

8230: Previously Unidentified Pickles

Because the Social Security Administration shared the Department's previous interpretation of the Pickle Amendment, many cases potentially eligible for Pickle status have been omitted from the yearly lists. The settlement agreement in Ciampa v. Schweiker requires that a thorough attempt be made to identify these cases retroactive to the 1977 closings.

Notices are being sent to all persons terminated from SSI because of excess income of any type, and these people are being given an opportunity to be reconsidered for Pickle eligibility. An AP/ADM-81 memo, unnumbered as of the printing of this handbook, describes the monitoring procedures required by the settlement.

Such notices will be sent on an ongoing basis until it is agreed by all parties that SSA Pickle Lists are substantailly complete.

Each former SSI recipient who responds to a notice from the Department suggesting that he may wish to apply for Medicaid as a Pickle, must complete an SS-37.

The SSI unit at Central Office will send SDX documents to the local office for each individual to whom such a notice is sent. Many former recipients will have moved from one WSO area to another; therefore if an SDX Document is not received for any individual who receives a notice, it should be requested from Central Office.

The worker uses the information on the SS-37 and the information transmitted from Central Office to ascertain

- A. termination date of SSI checks;
- B. amount of Social Security benefit at that time; .
- C. types and amounts of other sources of income, past and present; and
- D. current assets.

It will probably be necessary to contact the applicant in person, by mail, or by phone to ascertain the current living arrangement.



8230: Guidelines in Considering Possible Eligibility for Pickle StatusA. Eligibility under SSA and SSI must be concurrent

An individual who is terminated from SSI because he is awarded initial RSDI benefits is not eligible for Pickle status because he was never concurrently eligible for both programs. Even if he receives another SSI check after his first RSDI check, he cannot be given Pickle status because he was not eligible for the SSI check for that month.

B. Terminations Subsequent to Yearly Pickle Lists

An individual who continues to be eligible for SSI despite his RSDI cost of living increase (COLA), and is subsequently terminated from SSI for another reason cannot be considered for Pickle status until after the next RSDI COLA because the RSDI amount that would be used by the worker to determine the Pickle eligibility is the same amount that was used by SSI in the decision to terminate his benefits. If an increase in the SSI standards occurs in the meantime, he might be eligible again for SSI but he could not be eligible for MA as a Pickle case.



A. Contacting Potential Pickle Cases

As part of the implementation of the agreement in Ciampa v. Schweiker, the SSI unit at Central Office is sending letters (Attachment A) to all former SSI recipients whose names appear on the Social Security Administration's 1977 and 1978 Pickle lists unless:

1. current Pickle status is confirmed by an Action Code "13" in block 19 of the T.D.
2. the closing reason on the FMCS indicates that the recipient is deceased, or in the case of an SSI-D recipient, no longer disabled; or
3. the recipient is currently a resident of a long-term-care facility.

B. Determining Eligibility for Continued Medical Assistance as Pickle Cases

When a former SSI recipient contacts the local CSAO/WSO regarding the recipient of this letter, the eligibility worker will:

1. have him complete an MA application form (SS-37) to which an insert (Attachment E) has been added. This insert elicits information regarding the individual's living arrangements - a requirement in determining eligibility for Pickle status.
2. have the person designated by the director call the SSI unit at C.O. (727-8563) to request an SDX document for the individual. This SDX document and a Ciampa v. Schweiker monitoring form (Attachment D) will give information regarding types and amounts of income formerly received by the individual.

The SDX reference guide recently issued provides an extensive explanation of all data blocks on the SDX document. For present purposes, blocks 60-64 are of most concern to the worker. Under "data element 60", unearned income codes are listed. A "C" in block 64 indicates that the particular type and amount of income was being received at the time of termination of SSI.

The amount of Type A, (Social Security) will be provided by the Central Office SSI unit.

Types B-V should be explored since they were once received by the recipient.

Types W, X, Y, and Z should be ignored.

3. determine eligibility (other than income eligibility) for Pickle status according to instructions in 8300, keeping in mind the following:

A former SSI recipient must still be receiving RSDI in order

to be considered for Pickle status.

SSI Asset Standards are used in determining Pickle eligibility. An individual whose resources exceed \$1500 or a couple whose resources exceed \$2250 is not eligible for Pickle status. Once the resources are below these limits, (s)he may regain Pickle eligibility.

Since MA policy in 1977 and 1978 did not mandate verification of assets, the worker will have to exercise reasonable judgment in accepting the applicant's statements regarding past assets. Once past bills have been paid or reimbursement made, current policy regarding verifications will determine whether or not eligibility continues.

4. Determine the applicant's net countable income according to 8400. Note that financial eligibility is based on a comparison of countable income with the SSI payment standard for the living arrangement at that time. Charts showing the SSI payment standards since April, 1977 follow.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

## SSI PAYMENT STANDARDS SINCE APRIL 1977

APRIL 1976 - JUNE 30, 1977

Category	A Full Cost of Living Expenses	B Shared Living Expenses	C Household of Another	D* Commercial Boarding	E Domiciliary Care (Licensed R.H.)
<u>Individual</u>					
Aged	\$ 282.41	\$ 214.81	\$ 202.17	\$ 227.44	\$ 341.77
Disabled	\$ 271.54	\$ 206.60	\$ 189.54	\$ 214.81	\$ 341.77
Blind	\$ 306.59	\$ 306.59	\$ 306.59	\$ 306.59	\$ 306.59
<u>Member of a Couple</u>					
Aged	\$ 215.00	\$ 215.00	\$ 173.93	\$ 215.00	\$ 341.77
Disabled	\$ 206.85	\$ 206.85	\$ 165.79	\$ 206.85	\$ 341.77
Blind	\$ 306.59	\$ 306.59	\$ 306.59	\$ 306.59	\$ 306.59

JULY 1, 1977 - JUNE 30, 1978

<u>Individual</u>									
Aged	\$ 296.53	\$ 225.55	\$ 212.98		\$345.34				
Disabled	\$ 285.12	\$ 216.93	\$ 199.02		\$345.34				
Blind	\$ 321.92	\$ 321.92	\$ 321.92		\$321.92				
<u>Member of a Couple</u>									
Aged	\$ 225.75	\$ 225.75	\$ 182.63		\$ 345.34				
Disabled	\$ 217.19	\$ 217.19	\$ 174.08		\$ 345.34				
Blind	\$ 321.92	\$ 321.92	\$ 321.92		\$ 321.92				





## SSI PAYMENT STANDARDS SINCE APRIL 1977

JULY 1, 1978 - JUNE 30, 1979

Category	A Full Cost of Living Expenses	B Shared Living Expenses	C Household of Another	E Domiliary Care (Licensed R.H.)
Individual				
Aged	\$ 315.80	\$ 240.21	\$ 226.09	\$ 350.21
Disabled	\$ 303.65	\$ 231.03	\$ 211.96	\$ 350.21
Blind	\$ 342.85	\$ 342.85	\$ 342.85	\$ 342.85
Member of a Couple				
Aged	\$ 240.42	\$ 240.42	\$ 194.50	\$ 350.21
Disabled	\$ 231.31	\$ 231.31	\$ 185.40	\$ 350.21
Blind	\$ 342.85	\$ 342.85	\$ 342.85	\$ 342.85
JULY 1, 1979 - JUNE 30, 1980				
Individual				
Aged	\$ 336.01	\$ 255.58	\$ 240.55	\$ 350.21
Disabled	\$ 323.08	\$ 245.82	\$ 225.53	\$ 350.21
Blind	\$ 364.79	\$ 364.79	\$ 364.79	\$ 364.79
Member of a Couple				
Aged	\$ 255.81	\$ 255.81	\$ 206.95	\$ 350.21
Disabled	\$ 246.11	\$ 246.11	\$ 197.27	\$ 350.21
Blind	\$ 364.79	\$ 364.79	\$ 364.79	\$ 364.79



## SSI PAYMENT STANDARDS SINCE APRIL 1977

JULY 1, 1980 - JUNE 30, 1981

Category	A Full Cost of Living Expenses	B Shared Living Expenses	C Household of Another	E Domiciliary Care (Licensed R.H.)
<u>Individual</u>				
Aged	\$ 375.22	\$ 285.66	\$ 268.63	\$ 350.21
Disabled	\$ 360.79	\$ 274.83	\$ 251.85	\$ 350.21
Blind	\$ 396.14	\$ 396.14	\$ 396.14	\$ 396.14
<u>Member of a Couple</u>				
Aged	\$ 285.66	\$ 285.66	\$ 231.10	\$ 350.21
Disabled	\$ 274.83	\$ 274.83	\$ 220.29	\$ 350.21
Blind	\$ 396.14	\$ 396.14	\$ 396.14	\$ 396.14
JULY 1, 1981 -				
<u>Individual</u>				
Aged	\$ 401.92	\$ 312.36	\$ 286.43	\$ 444.68
Disabled	\$ 387.49	\$ 303.50	\$ 269.65	\$ 444.68
Blind	\$ 422.84	\$ 422.84	\$ 422.84	\$ 422.84
<u>Member of a Couple</u>				
Aged	\$ 305.66	\$ 305.66	\$ 244.44	\$ 444.68
Disabled	\$ 294.83	\$ 294.83	\$ 233.63	\$ 444.68
Blind	\$ 422.84	\$ 422.84	\$ 422.84	\$ 422.84





C. Disposition

If the worker determines that the applicant is eligible for Pickle Status, he mails a notice (Attachment C) to the applicant with the NFL-3, keeping a copy of each in the case record. He then enters the case on the RMF with an Action code "13" in block 19 and a "Y" in block 32. The medical start date is the actual date of eligibility or the date of the first medical bill incurred after the termination of his medical coverage as indicated on the VRER.

If the worker determines that the applicant is not eligible for Pickle status, he submits the case to the person designated by the office director for a second level review. If the reviewer agrees that the individual is ineligible for Pickle status, he and the worker complete and sign Attachment D, and the worker mails the denial notice (Attachment B) to the applicant with the NFL-5. He then determines current eligibility according to MA standards.

One copy of Attachment D for each case (whether approved or denied) is filed in the case record, and the second copy is sent to:

Mass. Department of Public Welfare  
Office of Field Operations, 5th Floor  
600 Washington Street  
Boston, MA 02111  
Att: SSI Unit

D. Monitoring Procedures

The Department is required to file reports with the Court and the Plaintiffs on June 1, 1982 and again on February 15, 1983 regarding the effect of the changes in policy and procedures. This report must include statistics concerning redeterminations as well as applications, using the new regulations for calculating Pickle. Each person living in the community who received SSI at any time after April 1977 is a potential Pickle case. This means the worker will be responsible for indicating that the possibility of Pickle eligibility has been considered for each Category 5 and 7 case at time of application and redetermination.

In order for Central Office to compile these statistics, workers must furnish information for the office application and redetermination logs that will indicate Pickle status as explained below.

- R - Determination of Pickle eligibility not applicable (i.e., person has never received SSI). Cases clearly marked "R" need not be considered for Pickle at next redetermination.
- P - Eligibility for Pickle status. Such cases are to be coded "13" in block 19 of the T.D. even though they may also be eligible as an MA case with no spend-down. This ensures their Pickle status.
- NP - Individual once received SSI, but is not currently eligible for Pickle status. Attachment B must be sent to the applicant/recipient until 2/15/83.

On the new SS-37 application form, the code R, P, or NP is to be placed on the second line of the disposition block. If the old SS-37 is used, it is placed on the disposition sheet. In the case of a denial, the second level reviewer also signs the disposition.

Copies of these logs will be sent to the SSI Unit at C.O. The worker must notify the director of the decision rendered by an appeals referee in any case involving denial of Pickle status since this information also will be required for the reports.

E. Payment of Bills Previously Designated as Responsibility of Recipient

1. Unpaid Bills Incurred Within Past 90 Days

If the date of service is less than 90 days prior to the current date, the recipient is given a NFL-3 and a temporary MA-ID card showing eligibility for the appropriate date(s) and instructed to contact providers immediately notifying them that this eligibility has just been approved. The medical start date is entered or corrected on the T.D., and providers bill in the usual manner.

2. Unpaid Bills Incurred Prior to Past 90 Days

When a bill that should have been paid by the Department is for a date of service 90 days or more prior to the current date, the recipient is given a copy of the NFL-3 showing the revised date of approval. He is also given a copy of the Attachment C notice and a temporary MA-ID card bearing the MA-ID number. When a recipient is eligible for two or more non-consecutive periods of time during the retroactive period, it may be necessary to issue more than one MA-ID card, each giving the appropriate dates of eligibility. The provider submits a copy of the NFL-3 with his late bill.

3. Reimbursement to Recipients for Bills Paid

Recipients are responsible for presenting an MA-ID card to the provider prior to receiving services. Reimbursement for bills paid by the recipient is made only as a result of a specific directive from Central Office as in the Ciampa case.

Reimbursement may be made to those eligible for Pickle status only for services covered by Medicaid, only in accordance with established fee schedules at the time of service, and only after submission to any other insurance by which the recipient was covered at the time of service. Forms RMB-1 and RMB-2 have been developed for use in direct reimbursement to eligible recipients.

The individual who requests reimbursement for medical bills paid for services rendered during a time he was erroneously considered ineligible, must give the eligibility worker the

dates of service and the names of any medical providers he has paid. The worker will give the recipient the appropriate number of copies of the provider letter (RMB-2), one for each provider.

In order to be reimbursed, it is necessary for the recipient to bring to the local office the paid medical bills or other statement from the provider giving the following information:

1. name of patient;
2. date(s) of service;
3. name, address, and MA provider number, when applicable: (Since these individuals may not have had MA coverage at the time, they may have bills from providers who do not participate in the Medicaid Program.)
4. type of service and procedure code, when known;
5. total amount billed for each service; and
6. indication of amount(s) paid by patient, insurance, or Genral Relief Medical Program.

Claim numbers for Medicare and/or other insurance must be obtained from the recipient if an amount already paid by Medicare or other insurance is not clearly designated on the bill.

Since the state "buys in" for Medicare B for SSI recipients over 65, those individuals determined to be eligible for Pickle status are also eligible to have the state pay their Medicare B premium.

If an individual awarded Pickle status retroactively under the Ciampa settlement agreement produces cancelled checks or receipts for Medicare B premiums paid during the time he was erroneously denied Medical Assistance, reimbursement may be made. The worker should photostat the proof of payment and include it with the RMB-1.

When all bills for which reimbursement is requested have been received and found to have the required information, the worker completes Request for Reimbursement Form (RMB-1). In the space after "Type of Case" at the bottom of the form, he writes "Ciampa," includes his case assignment number and sends the RMB-1 together with the bills to:

Department of Public Welfare  
Office of Field Operations  
600 Washington St., 5th Floor  
Boston, MA 02111

Att: SSI Unit

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

T8230

This office will serve as a clearing house in the reimbursement process. A copy of the RMB-1 indicating approval or disapproval of specific items will be returned to the worker for the case record.



NOTICE OF POSSIBLE MEDICAID ELIGIBILITY

Our records indicate that you may be eligible for the Massachusetts Medical Assistance Program under a 1976 Amendment to the Social Security Act known as the Pickle Amendment. If you are receiving full Medical Assistance now, you may disregard this notice. However, if you are not now receiving Medical Assistance, or if you are required to spend-down your surplus income to get a Medicaid card, this notice may be important to you.

PLEASE READ IT CAREFULLY.

You will be eligible for full Medical Assistance if you are one of the persons covered by the Pickle Amendment. The Pickle Amendment applies to you if, in the past, you received both Supplemental Security Income benefits (gold checks) and Social Security benefits (green checks) as well as Medical Assistance, and lost your SSI (gold checks) on or after April 1, 1977. If it is determined that you are covered by the Pickle Amendment, you will receive Medical Assistance even though you no longer receive SSI (gold checks).

If you think that you are one of the people covered by the Pickle Amendment, and if you are not getting full Medical Assistance now, please contact the Medicaid Section of your local Welfare Service Office.

' PLEASE TAKE THIS NOTICE WITH YOU WHEN YOU GO TO THE OFFICE.

This notice is the result of a Settlement Agreement approved by the Court in the case of Ciampa, et al. v. Schweiker, et al., U.S. District Court, District of Massachusetts, Civil Action No. 80-725-MA. The plaintiff class of Social Security recipients in the case were represented by lawyers in the federal legal services program.

If you have any questions, feel free to contact the Legal Services Institute, 3529 Washington Street, Jamaica Plain, MA 02130 (617) 522-3003, your local legal services office or your local attorney.





# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

Attachment B

## NOTICE

The Department of Public Welfare has determined that you are not eligible for Medical Assistance under the Pickle Amendment. If you have any questions about this decision, it is suggested that you contact the office of THE LEGAL SERVICES INSTITUTE, 3529 Washington Street, Jamaica Plain MA 02130; telephone (617) 522-3003. Attorneys at the INSTITUTE are now involved in representing a group of persons in a class-action law suit concerning Medical Assistance eligibility under the Pickle Amendment. That case is John Ciampa et al. v. Richard Schweiker, et al., U.S. District Court, District of Massachusetts, Civil Action No. 80-725-MA.

The INSTITUTE staff may be able to speak with you about what rights you may have under the Pickle Amendment. If it is more convenient, however, you may wish to contact a legal services office or an attorney closer to your home. If you do so, please show them this letter.

Signature of FAW \_\_\_\_\_

Date of NFL \_\_\_\_\_



SUPPLEMENTAL NOTICE OF MEDICAID ELIGIBILITY

Our records indicate that you are eligible for the Massachusetts Medical Assistance Program under a 1976 Amendment to the Social Security Act known as the Pickle Amendment. You may also be eligible for payment of and/or reimbursement for previously incurred medical expenses. Please Read This Notice Carefully.

If you have any unpaid medical bills that you incurred within the last three months, you may be eligible to have these bills paid by Medicaid. Contact your local Department of Public Welfare Medicaid office as soon as possible to find out if these bills may be paid.

If (a) you have any medical bills that you paid within the last three months, or if (b) you have any medical bills incurred longer than three months ago, that were paid or are unpaid, there are procedures available through which you may receive a determination as to whether you are entitled to payment or reimbursement. The local welfare office will assist you in claims for such payments and/or reimbursement. If you are not satisfied with the decisions of the Department, you have a right to file an appeal with the Division of Hearings.





# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

Attachment D

## CIAMPA V. SCHWEIKER (MONITORING)

This form is to be used with each determination of eligibility for Pickle status through 05/03/82. Complete in duplicate, retaining one copy for local office files and sending original to address below.

Name of Former SSI Recipient \_\_\_\_\_

Address \_\_\_\_\_

Social Security Number \_\_\_\_\_ Amount of RSNI for last month in which SSI received: \_\_\_\_\_

Determination of \_\_ / \_\_ / \_\_ shows:

☐ Eligible for Pickle status. Complete a or b below

a. \_\_\_\_\_ Recipient currently in open status with Action Reason "02" in Block 19. TD corrected on \_\_ / \_\_ / \_\_ to show Action Reason "13" in Block 19.

b. \_\_\_\_\_ Eligible for Pickle status. Opened on TD effective \_\_ / \_\_ / \_\_  
The following notices have been sent: ☐ Attachment C ☐ NFL-3

☐ Ineligible for Pickle status. Complete

Reason \_\_\_\_\_

Eligibility Worker \_\_\_\_\_

Second Level Reviewer \_\_\_\_\_

Title \_\_\_\_\_

The following notices have been sent:

☐ NFL-5 ☐ NFL-1

☐ NFL-8 ☐ Attachment B

☐ Other (Explain)

Send to: Department of Public Welfare  
Office of Field Operations  
600 Washington St., Fifth Floor  
Boston, Mass. 02111

Attn: SSI Unit



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

## Attachment E

In order to determine your eligibility for Medical Assistance under the Pickle Amendment, it is necessary to know your living situation. Please check the appropriate description below:

- ☐ Live alone in house or apartment
- ☐ Live with husband or wife
- ☐ Share living expenses (rent, utilities etc) with other person  
or persons
- ☐ Live in the home of another person or persons
- ☐ Live in a licensed rest home.

List below any changes in the above since termination of SSI payment. Indicate dates of change.





*The Commonwealth of Massachusetts*  
*Department of Public Welfare*  
*600 Washington Street, Boston 02111*

Dear Provider:

\_\_\_\_\_ of \_\_\_\_\_  
 (name) (address)  
 has been found eligible for Medical Assistance for the period --/--/-- to  
 --/--/--. If (s)he paid you directly for any medical services during this  
 period, (s)he may be eligible for reimbursement.

In order for the Department of Public Welfare to reimburse the recipient, we  
 need a statement from you giving the following information:

- Name of patient;
- Date of service;
- Provider name, address and MA Provider number when applicable;
- Type of service and Procedure Code if known;
- Total amount billed for each service; and
- Amount(s) paid by patient, by Medicare or other insurance, or  
 by the Department of Public Welfare's General Relief  
 Program (Category 4).

Thank you for your cooperation. If you have any questions regarding this  
 issue, please call \_\_\_\_\_  
 WSO tel.

Very truly yours,

\_\_\_\_\_  
 Financial Assistance Worker

\_\_\_\_\_  
 Welfare Service Office

RMB-2





# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

ATTACHMENT G



## *The Commonwealth of Massachusetts* *Department of Public Welfare*

### REQUEST FOR REIMBURSEMENT TO CLIENT FOR PAID MEDICAL BILLS

CSA Code \_\_\_\_\_ MSO Code \_\_\_\_\_ ELIGIBILITY PERIOD(S) \_\_\_\_\_

Name \_\_\_\_\_

Cat.    /    /   

Address \_\_\_\_\_

Soc. Sec. # 

--	--	--	--	--	--	--	--	--	--

### Summary of Receipted Bills

Dates of Service	Service and Procedure Code	Provider Name, Address, and Provider Number	Amount Paid by Recipient	Amount Paid by G. P.	Amount Paid by Other Insurance

Type of Case \_\_\_\_\_

Form RMB-1

CAN # \_\_\_\_\_



8321: RSDI Cost-of-Living Adjustments (COLA)

<u>Date</u>	<u>Percentage of Increase</u>
July 1, 1977	5.9%
July 1, 1978	6.5%
July 1, 1979	9.9%
July 1, 1980	14.3%
July 1, 1981	11.2%
July 1, 1982	7.4%





T8231 Compliance with the Court Order (Ciampa v. Schweiker)

A. Contacting Potential Pickle Cases

The implementation of the court order in Ciampa v. Schweiker expands the number of potential Pickle Cases. In May, 1983, BSO will send special Ciampa notices (Attachment A) to all former SSI/RSDI recipients whose cases were closed after April, 1977 unless:

1. current Pickle status is confirmed by an action code "13" in block 19 of the T.D.;
2. the individual is currently receiving SSI;
3. the individual is currently receiving full benefits of the Medical Assistance Program under another category;
4. the closing reason on the SDX or FMCS indicates the individual is deceased; or
5. the individual is currently a resident of a long term care facility.

B. Determining Eligibility for Continued Medical Assistance as Pickle Cases

When a former SSI recipient contacts the local CSAO/WSO regarding the receipt of this notice, the eligibility worker will:

1. have him complete an MA application form (SS-37) unless he is currently receiving assistance as a spenddown case on Cat. 5 or 7 and photostat his Medicare card if he has brought it with him as requested; and
2. determine eligibility (other than income eligibility) for Pickle status according to instructions in 8300, keeping in mind the following:

A former SSI recipient must still be receiving RSDI to be considered for Pickle status.

SSI Asset Standards are used in determining eligibility. An individual whose assets exceed \$1500 or a couple whose assets exceed \$2250 is not eligible for Pickle status. Once the resources are below these limits, he/they may regain Pickle eligibility.

3. use the special SDX document provided for this project to determine types and amounts of income formerly received by the individual. If there is no SDX document for a person who comes in for an application, he has probably moved since his termination from SSI. The worker should ask him where he lived previously or the location of his SSA District Office when he last received SSI. The worker may call Central Office at 727-8562 to obtain the SDX.

The SDX Reference Guide provides an extensive explanation of all data blocks on the SDX document. For present purposes, the fields which are circled are of most concern to the worker.

Blocks 6-8 can be used to verify information, i.e., recipient's age, Social Security Claim Number, and Social Security Number.

The closing code is in block 28. A "T" code indicates that the case has been closed for over one year and is purged from the file. An "N" code however states the reason for closing. This is an indicator to the worker of income, assets, etc.

The recipient's living arrangement at the time the case was terminated is in block 50F.

Under "data element 60", unearned income codes are listed.

Type A income is the Social security benefit to be used.

The applicant should be questioned regarding types B-V if he has not declared them on his SS-37 since these were former sources of income to him.

Types W, X, Y, and Z should be ignored.

The information in blocks 61-63 is useful as an indication of current unearned income.

A "C" in block 64 indicates that the particular type and amount of income was being received at the time of termination of SSI.

Blocks 67-80 show earned income at time of termination.

To determine the last month of receipt of SSI, the worker should refer to the VRER-20, either hard copy or fiche since the date of last termination appearing on the SDX may be a month or two later than actual date of termination.

4. Determine the applicant's net countable income according to section 8400. Note that financial eligibility is based upon a comparison of countable income with the current SSI payment standard for the appropriate living arrangement (See 8320).

If it appears that the applicant may now be eligible for SSI, the worker should refer him to the District Office of SSA but must still continue with the determination of current Pickle eligibility.

A copy of an SDX Document with the significant fields circled appears below.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE  
MEDICAL ASSISTANCE PROGRAM - Supplemental Security Income

### SUPPLEMENTAL SECURITY INCOME STATE DATA EXCHANGE

FOR: STATE - CITY - ZIP CODE: 1. TRANS CODE POS. 6 2. MED ELIG 3. ESS. PER 4. ADDED CASE 5. CONT. CASE 6. CURR. CASE

2. FIRST NAME 3. MI 4. LAST NAME 5. SEX 6. DATE OF BIRTH 7. TITLE II CLAIM NO. 8. SOC. SEC. NO.

9. PAYEE'S NAME AND ADDRESS 10. APPLICANT'S RESIDENCE ADDRESS 11. STATE I.D. NO.

12. ELIG. DATE 13. MO. AMT. 14. SUPP. AMT. 15. DATE STATE WUP 16. SUPP. AMT. 17. L.V. AMT. 18. MED. DET. DATE 19. DATE OF DEATH 20. MS

18. STATE/COUNTY CODE 19. ZIP CODE 20. STATE/COUNTY CODE 21. ZIP CODE

22. DIS. BLD. ON-SET DATE 23. DIS. BLD. CODE 24. JRD PARTY INS. COV. 25. JRD STATUS 26. RACE 27. RETRO MED. EXP 28. APPL DATE 29. DENIAL DATE 30. DENIAL CODE

31. JRD USE PAREN. SSN 32. ELIG. SPOUSE STATE I.D. NO. 33. REP PAY CUST. 34. REP PAY DATE 35. RES. DATE 36. CURR. TRANS DATE 37. TYPE

38. ESS. PERS. 39. ESS. PERS. STATE I.D. NO. 40. REPAY TYPE 41. REPAY GUARD 42. MBR LAF 43. SEP. DATE 44. SUPP. STATE COUNTY 45. HOM

46. PARENT #1 SSN 47. INDIVIDUAL \$ MULTIPLE SSN'S 48. JDF

49. CHARGEABLE EARN. INC. 50. CHARGEABLE UNEARN. INC. 51. DEEM EARNED 52. DEEM UNEARNED 53. RESOURCES 54. HOUSE 55. VEHICLE 56. INS. 57. PROP 58. OTHER

59. UN-EARNED INCOME 60. EARNED INCOME

61. PERIOD TYPE 62. STOP DATE 63. AMOUNT 64. CLAIM/I.O. NO. 65. VAL 66. YEAR 67. WAGE EST REPT 68. NET SELF EMP. EST

69. 70. WORK EXPENSE 71. EARNED INCOME EXCLUSION

72. ADV. PMT. 73. OVER PMT. 74. REC. WAIVE 75. OVER PMT. RECVY RATE 76. TOTAL UNEMPMT 77. STUD 78. DRUG ALCO 79. NEXT SCHED. REDETER. DATE 80. J. L.V. AM 81. SPEC. NEEDS

FORM SSA 8038 10-70-00M-240-152823



C. Disposition

## 1. Not Eligible for Pickle Status

If the worker determines that the applicant is not eligible for Pickle status, he submits the case to his supervisor or other person designated by the office director for a second level review. If the reviewer agrees that the individual is ineligible for Pickle status, he and the worker complete and sign the Ciampa Monitoring Form (Attachment D). The worker then determines current eligibility according to MA standards and mails the special Pickle denial notice (Attachment B) to the applicant with the NFL-5 or NFL-3 for the Cat. 5 or 7 case. One copy of Attachment D for each case is filed in the case record, and the second copy is given to the Director or designee to be sent on the next reporting date to:

Massachusetts Department of Public Welfare  
Central Services, 5th Floor  
600 Washington Street  
Boston, MA 02111

ATTN: Ciampa Monitoring

## 2. Eligible for Pickle Status

If the worker determines that the applicant is eligible for Pickle status, he sends the special Pickle approval notice (Attachment C) to the applicant with the NFL-3, keeping a copy of each in the case record. He completes and signs the Ciampa Monitoring Form, filing a copy in the case record and giving the second copy to the Director/Designee.

## a. Medicare Buy-In

Recipients of SSI who are eligible for Medicare B have their premiums for Medicare, Part B paid by the Department. Recipients of MA as Pickle cases are entitled to this payment also. Therefore the Department requires a Pickle recipient to apply for Medicare B as a condition of eligibility

If the applicant is eligible as a Pickle case, and is receiving Medicare Part B, or has applied for and is eligible to receive Medicare Part B, the worker must fill in the Medicare Buy-In Log (Attachment E). This log will be used by Central Office to notify the SSA that the Department will buy in for Part B for these recipients.

In filling out this log, the Medicare claim account number must be correct or buy-in will not be effective. The second through sixth columns are self-explanatory. The next five columns are:



Agency Code - always 220 (Massachusetts)

Buy-In Eligibility Code - always M

Transaction Code - always 41

These above three codes have been printed on each line of the log.

Transaction Date - the month in which the buy-in starts which is the first month of eligibility. For this project, it is the month of application.

SSN - the individual's own social security number.

These logs are sent monthly to the Ciampa Monitoring Unit at Central Office.

b. Entering Case on FMCS File

The case is entered on the RMF with an action code "13" in block 19. The correct claim account number must be entered in block 30, or the buy-in will not "take". In block 31, the appropriate code for the individual's current health insurance coverage is used. If the applicant currently has Medicare, Part B, code block 32 "Y". If the applicant has applied for and is eligible for Part B, but is not yet receiving it, code block 32 "N".

D. Monitoring Procedures

As for the earlier Ciampa project, the Department is required to file reports with the court and the plaintiffs. Each office must list all the applications received as a result of the Ciampa v. Schweiker notice (Attachment A) on a separate Ciampa Application Log. Instructions for monitoring are incorporated in AP/ADM-83-36.

E. Bills for Medical Services Received Between Date of Previous Last Month of Eligibility and Current Start Date

SSI does not provide for retroactive eligibility. Therefore, there is ordinarily no retroactive Pickle eligibility for new Pickle cases. If an individual requests retroactive Medical Assistance, he must complete page 8 of the MA Application Form, and a determination is made for category 5 or 7 in accordance with Section 2122.

The worker should be aware that there is a possibility the court will order retroactive reimbursement and/or payment of past bills for these recipients.

A provision of the Ciampa decision mandates that all applicants found eligible as Pickle cases as a result of this project will be sent a Supplemental Notice of Medicaid Eligibility (Attachment C) which suggests that they bring in past bills.

This notice informs the recipient that he may be eligible for reimbursement or for payment of medical bills incurred while he was considered ineligible for MA. If a recipient contacts the worker in response to this notice, the worker should ask him to bring in or send the bills, (or copies), receipts or cancelled checks, and proof of payment or partial payment by a liable third party (e.g. Medicare EOB). The worker should also ask for information regarding any health insurance coverage including proof of quarterly Medicare B premium payment in effect at the time the bills were incurred.

After determining that the bills were for services incurred between the date of termination of SSI (as shown on the VRER-20) and the date of eligibility for MA as a Pickle case, the worker should make copies of these bills and the accompanying documents for the case record.

If the recipient is present in the office, he should be requested to sign the Release of Information Form (Attachment F). The worker should explain that this will enable the Department to contact the provider if it becomes necessary at a later date. The worker must explain to the individual that there is a possibility that he will be reimbursed for these bills or that they will be paid by the Department in the future but that this has not yet been decided. The worker should not offer any opinion as to the decision.

#### The RMB-1

For each individual who brings in bills, the worker must fill out either one or two RMB-1 forms giving as much information as possible about the type of services, insurance payment etc.

Bills that have been paid by the recipient are listed on one form and "BILLS PAID" written at the top of the form. The "Bills Paid" RMB-1 should note whether the Medicare B premium amounts were paid directly by the recipient or were deducted from the Social Security check. Copies of the cancelled checks or award letters showing amount of the deduction should be kept in the case record with other bills.'

The Medicare B premium section may be ignored on the RMB-1 for "Bills Incurred."

Bills that were incurred but remain outstanding are listed on a second form, and "BILLS INCURRED" is written at the top. All RMB-1's are to be given to the Director/Designee, with a copy kept in the case record. They will then be forwarded to Central Office on the last working day of each month.

The separate Pickle Application Log must also be marked "BILLS PAID" and/or "BILLS INCURRED" next to the recipient's name.

F. Computing the RSDI Amount Used in Determining Pickle Eligibility

When the worker has established an individual's last month of SSI eligibility, he must then verify whether the amount of RSDI posted on the SDX document (block 63) was the amount in effect for that month. In situations where the Payment Status Code in block 28 is T31 (indicating that the SSI case has been closed for at least one year), the RSDI amount in block 63 will always be higher by one Cost of Living Adjustment (COLA) than the amount received in the last month of SSI eligibility, i.e., one COLA higher than the amount to be used in the calculation of Pickle eligibility.

The list of the RSDI COLA increases since July, 1977 is provided in Section 8321. This is to be used in cases in which the amount of RSDI received in the last month of SSI eligibility is not available from the SDX or from the recipient himself.

To determine the amount of RSDI for the previous year, the worker must divide the posted amount (block 63) by one (1) plus the cost of living adjustment percentage, and round down to the nearest ten cents (\$.10). See 8420.





COMMONWEALTH OF MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE  
NOTICE OF POSSIBLE MEDICAID ELIGIBILITY

May 16, 1983

Our records indicate you may be eligible for the State's Medical Assistance Program under a 1976 Amendment to the Social Security Act known as the Pickle Amendment. If you are receiving Medicaid now, you may disregard this notice. However, if you do not now receive Medicaid or if you must "spend down" your income to get a Medicaid card, this notice may concern you.

PLEASE READ IT CAREFULLY.

You will be eligible for full Medical Assistance if you are one of the persons covered by the Pickle Amendment, that is if:

- (a) You (and/or your spouse, if any) received both Supplemental Security Income (gold check) and Social Security (green check) benefits in some month after April, 1977;
- (b) You (and/or your spouse, if any) do not currently receive SSI (gold checks), but do receive RSDI (green checks); and
- (c) You (and/or your spouse, if any) would be eligible for SSI if all RSDI cost of living increases received by you and/or your spouse since the last month, after April, 1977 when either you and/or your spouse were eligible for and received both RSDI and SSI benefits, were deducted from your current income. (Over)

Reverse Side

To qualify for Medicaid under the Pickle Amendment, you must show that you currently reside in Massachusetts and that your total assets are less than \$1,500 for an individual or \$2,250 for a couple. If you think that you may be covered by the Pickle Amendment, and you are not getting full Medicaid coverage now, please contact your local Welfare Service Office. PLEASE TAKE THIS NOTICE AND YOUR MEDICARE CARD WITH YOU.

This notice is the result of a decision by the Court in the case of Clampa, et. al. v. Schwilke, et. al., U.S. District Court, District of Massachusetts Civil Action No. 80-225-MA. The Plaintiff class of Social Security recipients who have been denied medical benefits are being represented by lawyers at the Legal Services Institute, 3529 Washington Street, Jamaica Plain, MA 02130, (617) 522-3003.

If you have any questions, feel free to contact the Institute, your legal services office, or your own attorney.

The address of your local Welfare Office appears on the card with this notice.





*The Commonwealth of Massachusetts*  
*Executive Office of Human Services*  
*Department of Public Welfare*

Date: \_\_\_\_\_

NOTICE

The Department of Public Welfare has determined that you are not eligible for Medical Assistance under the Pickle Amendment. If you have any questions about this decision, it is suggested that you contact the office of THE LEGAL SERVICES INSTITUTE, 3529 Washington Street, Jamaica Plain MA 02130; telephone (617) 522-3003. Attorneys at the INSTITUTE are now involved in representing a group of persons in a class-action law suit concerning Medical Assistance eligibility under the Pickle Amendment. That case is John Ciamoa et al. v. Richard Schweiker, et al. U.S. District Court, District of Massachusetts, Civil Action No. 80-725-MA.

The INSTITUTE staff may be able to speak with you about what rights you may have under the Pickle Amendment. If it is more convenient, however, you may wish to contact a legal services office or an attorney closer to your home. If you do so, please show them this letter.

Signature of FAW \_\_\_\_\_

Date of NFL \_\_\_\_\_





*The Commonwealth of Massachusetts*  
*Executive Office of Human Services*  
*Department of Public Welfare*

Date: \_\_\_\_\_

SUPPLEMENTAL NOTICE OF MEDICAID ELIGIBILITY

Our records indicate that you are eligible for the Massachusetts Medical Assistance Program under a 1976 Amendment to the Social Security Act known as the Pickle Amendment. You may also be eligible for payment of and/or reimbursement for previously incurred medical expenses. Please Read This Notice Carefully.

If you have any unpaid medical bills that you incurred within the last three months, you may be eligible to have these bills paid by Medicaid. Contact your local Department of Public Welfare Medicaid office as soon as possible to find out if these bills may be paid.

If (a) you have any medical bills that you paid within the last three months, or if (b) you have any medical bills incurred longer than three months ago, that were paid or are unpaid, there are procedures available through which you may receive a determination as to whether you are entitled to payment or reimbursement. The local welfare office will assist you in claims for such payments and/or reimbursement. If you are not satisfied with the decisions of the Department, you have a right to file an appeal with the Division of Hearings.

Signature of FAW \_\_\_\_\_







*The Commonwealth of Massachusetts*  
*Executive Office of Human Services*  
*Department of Public Welfare*

CIAMPA v. SCHWEIKER MONITORING FORM

Complete in duplicate, retaining one copy for local office files. Send original to Central Office with weekly Ciampa v. Schweiker Statistical Report.

NAME OF FORMER SSI RECIPIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

Individual ☐ Is individual a disabled child? ☐ YES ☒ NO

Couple ☐ Did both members of the couple receive SSI after 1/1/77?  
☒ YES ☐ NO

Complete the following for each case eligible to the state in which the computation was necessary to determine eligibility.

- Last month of eligibility for and receipt of concurrent SSI and RSDI \_\_\_\_\_
- RSDI amount received in that month \_\_\_\_\_
- Total current monthly income, not including RSDI \_\_\_\_\_
- Current Living Arrangement \_\_\_\_\_
- Attach a copy of the SDI document

☒ Eligible for Pickle status

Open on FMCS effective \_\_\_\_/\_\_\_\_/\_\_\_\_.

The following notices have been sent:

☐ NFL-3 ☐ Attachment C

☐ Ineligible for Pickle status

Denied due to: 1. ☐ Excess Assets (State Total) \_\_\_\_\_

2. ☐ Excess Income (State Total) \_\_\_\_\_

3. ☐ Other (Please explain) \_\_\_\_\_

4. Lack of Verifications (Please specify) \_\_\_\_\_

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

ATTACHMENT D  
page 2

The following notices have been sent to the former SSI recipient.

- ☐ MFL-5
- ☐ MFL-8
- ☐ Attachment 3

SIGNATURES:

\_\_\_\_\_

SECOND LEVEL REVIEWER (Denials Only)

\_\_\_\_\_

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

ATTACHMENT E

The Commonwealth of Massachusetts  
Executive Office of Human Services  
Department of Public Welfare

Date \_\_\_\_\_

## MEDICARE BUY-IN LOG

Medicare Claim No.	Last Name	First Name	MI	SEX M=1 F=2	DOB MMDDYY	Agency Code	Buy-In Eligibility Code	Trans- Action Code	Transaction Date MMYY	SSN
						220	M	41		
						220	M	41		
						220	M	41		
						220	M	41		
						220	M	41		
						220	M	41		
						220	M	41		
						220	M	41		
						220	M	41		
						220	M	41		







*The Commonwealth of Massachusetts*  
*Executive Office of Human Services*  
*Department of Public Welfare*

Release Form

Date: \_\_\_\_\_

I \_\_\_\_\_ hereby authorize representatives of the Massachusetts Department of Public Welfare to obtain medical data maintained by my providers of health care whenever such data is necessary for the administration of the Department's programs of public assistance. Said data shall include, but may not be limited to, the following:

Name of patient;

Date of service;

Provider name, address and MA Provider number when applicable;

Type of service and Procedure Code if known;

Total amount billed for each service; and

Amount(s) paid by patient, by Medicare or other insurance, or by the Department of Public Welfare's General Relief Medical Program (Category 4).

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE





## CSAO/WSO CODE

ELIGIBILITY PERIOD(S)

NAME \_\_\_\_\_

CAT. 177

ADDRESS .

[illegible]

## DESCRIPTION OF INCURRED BILLS

Dates of Service	Description of Service	Provider Name, Address, and Provider Number	Amount Paid by Recipient	Amount Paid By GR Medical	Amount Paid By Other Insurance

Type of Third Party Coverage  
Held by Recipient

Claim Number(s)

### Medicare B Premiums

9

---

☐ Paid by recipient

     Deducted from  
SSA benefit

 Coverage dropped

Type of Case \_\_\_\_\_

CAN # \_\_\_\_\_

RMB-1 (5/83)





*The Commonwealth of Massachusetts*  
*Executive Office of Human Services*  
*Department of Public Welfare*

CIAMPA v. SCHWEIKER STATISTICAL REPORT

A. Ciampa Project Weekly Report

To be completed each Tuesday, May 31, 1983 through August 30, 1983.

- . SS 37's requested to date as a result of Ciampa notice \_\_\_\_\_
- . Redeterminations completed since last weekly report \_\_\_\_\_
- Attach a Ciampa Monitoring Form for each redetermination
- . Number of appeals filed \_\_\_\_\_
- . Number of denials reversed \_\_\_\_\_
- . Number of Ciampa notices returned as undeliverable \_\_\_\_\_

B. Monthly Pickle Status Report

To be completed on last Tuesday of each month May 31, 1983 through April 25, 1984.

- . Number of SSI related applications and redeterminations (Categories 5 and 7) from previous month's MA Application Log. \_\_\_\_\_
- ... Individuals approved for Pickle Status (P) \_\_\_\_\_
- ... Individuals that once received SSI but are not currently eligible for Pickle status (NP) \_\_\_\_\_
- ... Individuals that never received SSI (R) \_\_\_\_\_
- . Number of appeals filed \_\_\_\_\_
- . Number of denials reversed \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_





8300 SSI ASSET AND INCOME STANDARDS

An individual or couple may be eligible for Medical Assistance under the Pickle Amendment if he (they) would currently be eligible for SSI but for the Social Security cost-of-living increases since the last month in which he (they) were eligible for and received SSI.

Anyone whose application for MA indicates that he once received SSI must be considered for possible Pickle status at application and at each redetermination.



8330: Verifications

Verification of income and assets as well as any other verifications necessary to establish eligibility must be provided in accordance with procedures outlined for regular SSI-related Medicaid cases. Age and citizenship verification is waived, however, since these have already been verified by SSA. Pickle eligibility is established upon verification of:

- A. date of termination of eligibility for SSI payments (gold check);
- B. present receipt of Social Security Disability or Aged benefits (not early retirement);
- C. amount and type of RSDI benefit (green check) for the last month in which the individual (and/or spouse if any) was eligible for and received an SSI payment, and
- D. all current income other than Social Security benefits.

Except for cases appearing on the yearly Pickle Lists and in projects where special instructions are issued, documents from SSA (e.g. award letters, termination notices, confirmation on SSA letterhead) must show that receipt of SSI and SSA benefits (A and C above) were concurrent.





8340: "Buy-Ins" (Medicare B - Supplemental Medical Insurance Benefits)

Massachusetts has contracted to pay Medicare Part B premiums for all SSI-A recipients who receive Social Security Benefits and for disabled SSI-D recipients who have been disabled for at least 24 months.

This agreement does not include Medicaid-only recipients. Therefore when an individual loses his Pickle status, he also loses his free Part B coverage.

The worker should be aware that there will be a decrease in the Social Security benefit or the individual will be billed for Medicare B. He cannot be required to purchase Medicare B but since as a non-Pickle, he will have a spend-down liability, there is no financial advantage in not continuing his enrollment in Medicare B.



8400: CALCULATION OF FINANCIAL ELIGIBILITY

Financial eligibility for Pickle Status is calculated by following Steps 1 through 4 below.

THE AMOUNT OF THE SOCIAL SECURITY BENEFIT FOR THE LAST MONTH OF SSI ELIGIBILITY IS THE SOCIAL SECURITY AMOUNT TO BE USED IN ALL FUTURE CALCULATIONS OF PICKLE ELIGIBILITY UNLESS THERE IS A CHANGE IN THE SOCIAL SECURITY BENEFIT OTHER THAN A COST OF LIVING INCREASE.

Step 1: From the amount of the Social Security benefit for the last month of SSI eligibility\*, subtract the SSI-unearned income disregard of \$20 per individual or per married couple.

Step 2: If there has been a change in the Social Security benefit other than the cost-of-living increase (such as a change from spouse's to widow's benefits), add to the result of Step 1 the amount of the difference between the old and new types of benefit at the time of the change.

Step 3: Add to the result of Step 2 all current countable non-Social Security income. (If there is earned income, be sure to allow the \$65 and one-half of remainder disregards. Note that SSI does not allow a deduction for health insurance.)

Step 4: Compare the result of Step 3 to the appropriate SSI payment standard for the individual's or couple's present category and living arrangement. If it is less than the SSI payment standard, Pickle eligibility is established. If it exceeds the SSI payment standard, an application for MA/DA or MA/OAA may be filed and eligibility determined using the actual Social Security benefit currently received.

\*Note: If an SSI case has been closed for more than one year, a code "T31" will appear in block 28 of the individual's SDX Document. This means that the RSDI amount in block 63 of the SDX document is at least one COLA higher than the amount of RSDI actually received in the last month of SSI eligibility. A table listing the SSA COLA's is provided in Section 8321 for use in calculating the appropriate amount to be used for determination of Pickle eligibility.

# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

8410

## 8410: Examples

In each of the following examples, it is assumed unless stated otherwise, that the former SSI recipients meet the basic and categorical eligibility requirements and are within the SSI asset limitations of \$1500 for an individual and \$2250 for a couple.

## 8411: SSI Payments Terminated Due to Hospitalization

Mrs. Vlasic, who lives alone, has an endowment policy that began paying her \$25 per month for life when she reached her 65th birthday. In April of 1978 Mrs. Vlasic was hospitalized. At that time she was receiving a Social Security check of \$293 and an SSI check of \$2.75 per month. After a month in the hospital, her SSI check was suspended.

When an SSI recipient has been hospitalized for a full calendar month, SSI suspends cash benefits. The case remains open for medical coverage on the category 01 or 03, and is reinstated for cash benefits upon his return to the community unless he has become ineligible for another reason in the meantime.

If he goes from the acute hospital to a long-term-care facility, SSI is terminated unless it is the sole source of income.

There is never any Pickle eligibility while an individual is in a long-term-care facility.

As a result of the July, 1978 cost of living increase, Mrs. Vlasic's Social Security benefit was raised to \$312.10, which combined with the endowment check made her ineligible for SSI when she returned home at the end of July. She applied for Medical Assistance, but because her SSI checks had been suspended earlier than July, it was not realized that she could be eligible as a Pickle case; she was told that her monthly spend-down was \$17.10 ( 102.60 for 6 months). Mrs. Vlasic met this spend-down and at time of subsequent re-determinations has usually met the increasingly larger spend-down amounts. She has not yet met the spend-down for the current six-month period, however.

Now Mrs. Vlasic receives a letter from the Department stating that she may be eligible for Medicaid without a spend-down liability. Her eligibility is determined as follows:

### Step 1

Social Security in May 1978	\$293.00
SSI Unearned Income Disregard	<u>-20.00</u>
	\$273.00

8411 (con't)

Step 2

Not applicable in this case

Step 3

Current Non-Soc. Sec. Income	+25.00
Total "Pickle" Income	<u>\$298.00</u>

Step 4

Current SSI Payment Standard	\$401.92
Full Cost of Living Expenses	

Mrs. Vlastic's countable income is less than the current SSI payment standard for her age and living expenses. She is a Pickle case.

8412: Loss of Pickle Status Due to Change in Living Arrangement

Mrs. O'Brine was receiving \$316 in Social Security benefits between July 1977 and June 1978. She was also receiving an SSI check for \$4.75.

Due to the cost of living, Mrs. O'Brine's Social Security benefit was increased to \$336.60 in July 1978, and she was terminated from SSI but retained Medicaid as a Pickle. In January Mrs. O'Brine's cousin moved in with her to share expenses. She was no longer eligible for Pickle status.

Mrs. O'Brine now receives a letter from the Department stating that she may be eligible for Medicaid with no spend-down liability. Under the previous interpretation of policy, Mrs. O'Brine would not be eligible for consideration as a Pickle because there has been a change in her circumstances other than the Social Security cost-of-living increase (sharing of living expenses).

Under the Ciampa decision, however, eligibility is determined as follows:

Step 1

Social Security in June 1978	\$316.00
SSI unearned Income Disregard	<u>-20.00</u>
Countable Social Security Income	\$296.00

Step 2

No Change in Type of Soc. Sec.



8412 (con't)

Step 3

No Income Other than Soc. Sec.

Step 4

Total Countable Pickle Income	296.00
SSI Payment Standard for Shared Living Expenses	\$312.36

Mrs. O'Brine's countable income is less than the SSI current payment standard; therefore she is a Pickle

The SSI Payment Standard for shared living expenses (aged) has increased from \$218.07 for 1976-1977 to \$312.66 for 1981-1982.

In order to determine when Mrs. O'Brine should actually have regained her Pickle eligibility, it would be necessary to look back at the payment standards for the intervening years. Mrs. O'Brine's countable income for Pickle purposes has remained at a constant \$296. This exceeded the 1980-1981 payment of \$285.66. Her eligibility for Medicaid with no spend-down began in July 1981.

8413: Loss of Pickle Status Due to Receipt of Other Income

Mrs. Salmwera lives alone. She was receiving Social Security Disability of \$308 and an SSI benefit of \$2.00 in 1977-1978. The July 1978 cost-of-living increase brought her Social Security to \$326.20, and her SSI was terminated.

Mrs. Salmwera was a Pickle case until December of that year when she sublet a room in her apartment for \$60 a month and lost her Pickle eligibility because of a change other than the Social Security cost-of-living increase.

In February 1979 Mrs. Salmwera turned 65, and her Social Security benefit increased from \$326.50 to \$348.

She is now being considered for eligibility as a possible Pickle.

Step 1

Social Security, June 1978	\$308.00
SSI Disregard	<u>-20.00</u>

8413 (con't)

Step 2

Adjustment for Soc. Sec.	288.00
Change Other than Cost of Living	<u>+11.80</u>
	\$299.80
348.00	
<u>-326.00</u>	
11.80	

Step 3

Rent for Room (Increased to \$75.00 per month on 1/1/80)	75.00
---	-------

Step 4

Total Countable Pickle Income	\$374.80
Current SSI Payment Standard	
Full Cost of Living Expenses	\$401.92

Her countable income is less than the current SSI payment standard for a person over 65 living alone. She is a Pickle.

8414: Loss of Pickle Status Due to Increase in Income Other Than SSA

Dorothy Dill is a 32-year old retarded adult living in the home of her parents and working part time in a sheltered workshop. In June 1979 she was receiving \$4.50 SSI along with \$30 per week from the workshop and \$195 per month Social Security. With the cost of living increase in July Dorothy began receiving \$214.30 in Social Security and her SSI case was terminated.

Dorothy began receiving \$45.00 per week from the workshop in January 1980 and lost her Pickle eligibility.

Current Pickle is determined as follows:

Step 1

Social Security June 1979	\$195.00
SSI Disregard Unearned Income	<u>-20.00</u>
	175.00

Step 2

Not applicable in this case

8414 (con't)

Step 3

$45 \times 4 \frac{1}{3} = 195$   
 $\begin{array}{r} -65 \\ 2)130 \\ -65 \\ \hline 65 \end{array}$

Current Non-Soc. Sec. Income + 65.00  
\$240.00

Step 4

Current SSI Payment Standard  
 Disabled Living in Household  
 of Another \$269.65

Dorothy's countable income is less than the applicable SSI payment standard, and she is a Pickle. Looking back over the previous SSI payment standards shows she should have regained Pickle status in July 1980 when the payment standard for her living arrangement increased from \$226.48 to \$269.65.

8415: Change in Type of Social Security Benefit

In June of 1977 Mr. Poekel was receiving a Social Security check of \$302 per month, and his wife was receiving \$151. She was also receiving an SSI check for \$3.00. When the July Social Security increase raised their combined income to \$479.70 (\$159.90 for Mrs. Poekel and \$319.80 for Mr. Poekel). Mrs. Poekel was no longer eligible for SSI.

In October, Mr. Poekel died and Mrs. Poekel's entitlement became \$319.80. She lives alone at the present time. Pickle eligibility is determined as follows:

Step 1

Mrs. Poekel's Social Security in June, 1977 \$151.00  
 SSI Unearned Income Disregard  $\begin{array}{r} -20.00 \\ \hline \end{array}$   
\$131.00

Step 2

Widow's Benefit \$319.80  
 Spouse's Benefit -159.90  
 Adjustment for New Type of  
 Benefit  $\begin{array}{r} 159.90 + \\ \hline +159.90 \\ \hline \end{array}$   
\$290.90

Step 3

Not applicable

Step 4

Current SSI Payment Standard

Individual - aged

\$401.92

Mrs. Poekel would actually have been eligible for SSI if she had reapplied after her husband's death.

8416: Assets in Excess of SSI Limits/Enters LTC Facility

Mr. Cornichon, who is disabled, was receiving \$315 in Social Security Disability benefits in June, 1978. The cost of living increase that year gave him a benefit of \$335.50, making him ineligible for SSI. In July Mr. Cornichon entered an acute hospital and in September was transferred to a nursing home, where he remained until mid-November.

While in the acute hospital Mr. Cornichon was still "protected" on the Pickle list as a category 03 case. His August, September, and October Social Security checks were deposited in his bank account, and since he gave up his apartment, his account soon exceeded \$1500.

When an SC-1 from the nursing home was received in the local office in September Mr. Cornichon's case was opened as a regular MA case with a monthly spend-down at that time of \$15.50 per month. When he left the hospital, his bank account totaled \$1875, which would have made him ineligible for Pickle status. Within the month, however, after paying his rent and security deposit for a new apartment, Mr. Cornichon's resources were below \$1500, and he should have regained Pickle status.

The Social Security amount he was receiving in June 1978 is the amount which should still be used in determining his eligibility.





8417: MEMBERS OF A COUPLE

In determining eligibility for a couple, SSI considers the total income of both husband and wife.

- A. If both are eligible to be considered for Pickle eligibility, the appropriate combined payment standards are compared to the combined total income using the SSA amounts received in the last month of eligibility for and receipt of SSI. If the income is less, any payment benefit is divided equally between husband and wife and both are eligible for Medical Assistance.

In December of 1981 Edward and Anna Sweet were both receiving SSI; Edward, SSI-A; Anna, SSI-D. Their non-SSI income was as follows:

Anna's Social Security	\$155
Edward's Social Security	310
Total Social Security	<u>465</u>
SSI-related disregard	-20
	<u>445</u>
Edward's pension	145
Couple's Total Countable Income	<u>\$590</u>

The SSI payment standard for members of couples was \$294.83 for disabled and \$305.66 for aged.

Standard

Anna	\$294.83
Edward	305.66
	<u>\$600.49</u>
Countable Income	590.00
Deficit	<u>\$ 10.49</u>

Anna and Edward were each eligible for \$5.25.

In January, 1982 Edward's pension was increased to \$170, bringing the couple's total countable income to \$615.

Anna's Social Security	\$155
Edward's Social Security	310
Total Social Security	<u>465</u>
SSI related disregard	-20
	<u>445</u>
Edward's pension	170
Total Countable Income	<u>615</u> exceeds \$600.49

The Sweets were terminated from SSI. They would not be eligible for Pickle status until 7/1/82 when the SSI standards were increased to \$309.53 and 320.36  
\$629.89

- B. If both members of a couple are categorically related to SSI, but only one is eligible to be considered as a Pickle (the other one never having received SSI), the appropriate combined payment standards are compared to the combined total income using the "frozen" SSA benefit of the member eligible to be considered as a "Pickle".

Guido Gherkin and his wife Ginny apply for MA on 2/83. Both are over 65. Guido received SSI of \$5.66 and SS of \$300 in June 1982. His SSI was terminated when his SS was increased in July 1982 to \$330/month. Ginny is currently receiving Social Security of \$250 per month. They have combined assets of \$1,000.

Guido's Pickle eligibility is determined as follows:

300.	Guido's SS at last receipt of SSI
<u>350</u>	Ginny's current Social Security
650	
<u>-20</u>	SSI-related Disregard
630	The combined SSI standard for both is \$640.72 ( $320.36 \times 2$ )

Since the income is less than the combined standard, Guido is eligible as a Pickle.

Ginny's eligibility would be determined as a regular MA case because she was never a recipient of SSI.

350	Pension
<u>-20</u>	SSI Disregard
330	Less than the MA Standard for 1 of 333

Ginny is eligible for MA. None of Guido's income is countable since he is a Pickle case.

#### 8418: Termination of SSI Due to Receipt of Other Income

John Champion was receiving Social Security of \$327.10 and an SSI Disability check for \$3.45 in July of 1978. In October 1979 he was awarded a Veteran's benefit of \$44 per month, and his SSI benefit was terminated. In July, 1980 his Social Security increased to \$348.36; the Veteran's benefit remained at \$44. He claims that the Social Security increase should not be counted in determining his eligibility for Pickle status because it was just unfortunate timing that he received the Veteran's benefit first.

8418 (con't)

Step 1

Soc. Sec. Nov. '79 (last month of SSI)	\$327.10
SSI-Disregard	<u>-20.00</u>
	\$307.10

Step 2

Not applicable

Step 3

Current Veteran's Benefit	<u>44.00</u>
	\$351.10

This was less than the SSI-D standard of \$360.79 effective July 1, 1980. Mr. Champion is correct. He should have been eligible for Pickle status effective July, 1980.

8419: On Again/Off Again

Once attained, Pickle eligibility cannot be counted on. The following example combines several of the issues illustrated in the previous examples as a warning of the complexity of the problem and the enormous potential for QC errors.

In the early part of 1979 Mrs. Rassol was 66 years old, living alone and receiving SSI as well as Social Security and a small Veteran's pension.

<u>Income</u>		<u>SSI Payment Standard</u>	
Social Security	\$308	\$325.79	Full Cost-of-Living
SSI-Disregard	<u>-20</u>		Expenses
	288	313.00	Mrs. Rassol's Countable
Veteran's Pension	<u>+25</u>		Income
Countable Income		\$ 2.79	Deficit/SSI Benefit
for SSI Purposes	\$313		

After the July 1979 Social Security cost-of-living increase, Mrs. Rassol's income was

Social Security	\$338.50
SSI Disregard	<u>-20.00</u>
	318.50
Veteran's Pension	<u>+25.00</u>
Countable Income	
for SSI purposes	\$343.50

8419 (con't)

Mrs. Rassol's countable income was more than the SSI payment standard; she was no longer eligible for SSI. Under the Pickle Amendment, however, she remained eligible for medical assistance. Her countable amount of Social Security is fixed at \$308, the amount she was receiving prior to the cost-of-living increase that rendered her ineligible for SSI.

In October, 1979, Mrs. Rassol's Veteran's Pension was increased to \$50.

<u>Income</u>	<u>SSI Payment Standard</u>
Countable Social Security	\$337.43
SSI Disregard	
-20	
<u>288</u>	
Veteran's Pension	
+50	
Countable Income	
\$338	
for Pickle Status	

Mrs. Rassol's total countable income exceeded the SSI Payment Standard at that time for her living arrangement. Mrs. Rassol lost her Pickle eligibility and applied for MA as a regular MA case.

Current Social Security	\$338.50
Veteran's Pension	+50.00
Total Income	<u>\$388.50</u>
SSI Disregard	-20.00
Net MA Income	<u>\$368.50</u>
MA Income Standard 10/29	-317.00
Excess MA Income	<u>51.50</u>
	X 6
Six-month Spend-down Liability	<u>\$309.00</u>

The case does not end here, however, with the July of 1980 cost-of-living increase, Mrs. Rassol's Social Security benefit became \$386.80. Her countable Social Security was still only \$308, the amount received in June of the year in which her SSI terminated.

Social Security	\$308	New SSI Payment Standard for Full Cost-of-Living Expenses
Disregard	-20	
	<u>\$288</u>	
Veteran's Pension	+50	\$375.22
Countable Income		
for Pickle Purposes	\$338	

8419 (con't)

The SSI payment standards increased and Mrs. Rassol's countable income was again less than the SSI Payment Standard for her living arrangement; she therefore regained her Pickle eligibility. The last month in which Mrs. Rassol should have had a spend-down liability was June 1980.

Mrs. Rassol retained her Pickle status through July 1981 Social Security cost-of-living increase that resulted in benefit rising to \$430.10, because the countable amount remained at \$308 and her total countable income remained at \$338.

In November 1981, however, Mrs. Rassol and her sister decided to live together and share expenses. Her countable income of \$338, while well below the SSI payment Standard of \$391.92 for full cost of living expenses is greater than the payment standard of \$301.36 for her new living arrangement (shared living expenses).

Countable Income for	\$308	SSI Shared Living Expenses
Pickle Status		\$301.36
SSI Disregard	-20	
	<u>\$288</u>	
Veteran's Pension	+50	
Total Pickle Income	<u>\$338</u>	

Mrs. Rassol has lost her Pickle status this year because of a change other than the accumulated Social Security cost of living increases. She files an application for MA.

\$430.20	Actual Social Security
+50.00	Veteran's Pension
<u>480.20</u>	Total Income
-20.00	SSI Disregard
<u>460.20</u>	Net MA Income
333.00	
<u>127.20</u>	Excess Monthly Income
x6	
<u>\$763.20</u>	Spend-down Liability

She now has a six-month spend-down of \$763.20. In July, 1982, however, if the SSI payment standards increase at the same rate as this year, she will very likely regain her Pickle status.





# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

8420

## 8420: Use of SDX Document and COLA Tables to Determine RSDI

Mr. Quke, age 73, was terminated from SSI in September, 1977, when he began to receive Veteran's benefits in addition to his Social Security benefits. The SDX document has a T31 payment status code in block 28 and an RSDI amount of \$225 in block 63. This amount would include the July, 1978 COLA, but the worker must use the RSDI amount Mr. Quke was receiving in August, 1977 to determine his Pickle eligibility.

To obtain the August, 1977 RSDI amount the worker must divide by one (1) plus the COLA percentage and round down to the nearest ten cents. The RSDI cost of living increase in 1978 was 6.5%.

$$\begin{array}{r} 211.267 = \$211.20 \\ 1.065 \overline{) 225.00} \end{array}$$

Mr. Quke's current Veteran's benefit is \$220 per month.

Mr. Quke's Pickle eligibility is determined as follows:

\$220.00	Current Veteran's benefit amount
<u>211.20</u>	August, 1977 RSDI amount
\$431.20	Countable unearned income
<u>-20.00</u>	SSI disregard
\$411.20	Net countable Pickle income

This is compared to the current SSI Payment Standard.

\$421.52	Current SSI Payment Standard for an Aged Individual
<u>-411.20</u>	Total countable Pickle income.
\$ 10.32	Mr. Quke is eligible for MA under the Pickle Amendment.



8500: MEDICAID BENEFITS FOR CERTAIN DISABLED WIDOWS AND WIDOWERS

For certain widows and widowers who had been receiving Supplemental Security Income (SSI) benefits a special increase in social security benefits they received in 1984 caused them to lose SSI and Medicaid.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 provides categorical eligibility for these certain widows and widowers by requiring this special increase and any subsequent cost-of-living adjustments to be disregarded in determining current eligibility. (See Section 504.560 for the provisions of eligibility.)

The individuals affected by this provision have been identified to the Department by the Social Security Administration. The Central Office Special Projects Unit will notify these individuals by letter that they may be eligible for Medicaid under the special provision of the Social Security Act if they apply before July 1, 1987.

For recipients of this letter who apply for retroactive medical payments, eligibility will be determined in the same manner as for all applicants for Medicaid. (See Section 2121 of the MA Handbook.)

The special income disregard is permanently available to these individuals provided they apply for Medicaid before July 1, 1987, and are determined to be eligible under this provision.

A notice will be sent to local offices identifying each individual as a current recipient or potential applicant. The notice will contain the amount of the special income disregard and the amount of the current countable (frozen) RSDI benefit.

Workers must follow existing procedures for Pickle cases (Sections 8000 through 8419) in determining Pickle eligibility and allow the additional special income disregard in determining current eligibility.

Once an individual is determined to be eligible, use the same code that is used to open Pickle cases (code "13" in Block 19 of the TD).

8510: Medicaid Benefits for Disabled Widows and Widowers (Age 60-64)

Disabled widows and widowers who lost eligibility for SSI on or after July 1, 1988 may continue to be eligible for Medicaid if they:

- . are between the ages of 60 and 65;
- . are eligible for and receiving certain early widow(er)'s RSDI benefits;
- . are not entitled to Medicare Part A; and
- . became ineligible for SSI because of receipt of early widow(er)'s benefits but would still be eligible for SSI if these benefits were disregarded in the calculation of financial eligibility.

The data for determining eligibility for these cases can be found on the SDX documents generated by the SSI-MAOA system or SDX inquiry screens. These individuals will have a current or former RSDI claim suffix of "D" or "W" and the case characteristics listed above. You should determine eligibility in the same way as a Pickle case, disregarding the amount of the RSDI described above. Use Action Reason 13.

You should also be aware that these individuals will become ineligible for MA under this provision when they reach age 65 or become eligible for Medicare Part A.



8600: MEDICAID BENEFITS FOR DISABLED ADULT CHILDREN

Under the Social Security Act a disabled person aged 18 or over (whose disability began before the age of 22), is eligible for a monthly disabled adult child's (DAC) RSDI benefit if that person is the child, eligible grandchild, or great grandchild of a retired, deceased, or disabled worker.

Disabled adult children who lost SSI on or after July 1, 1987, because of receipt of or an increase in RSDI benefits may continue to be Medicaid eligible provided they:

- . are at least 18 years old;
- . were receiving SSI based on a blindness or disability that began before he or she attained the age of 22; (NOTE: An individual need not have received SSI prior to age 22, but must have been disabled prior to age 22.)
- . lost SSI as a result of receipt of or an increase in these RSDI benefits on or after July 1, 1987; and
- . would still be eligible for SSI if the amount of the benefit or benefit increase were disregarded in the calculation of financial eligibility.

The information needed to determine eligibility for these cases can be found on the SDX documents generated from the SSI-MAOA system or SDX inquiry screens. Some clients will have a Medicaid referral code of "D" on their SDX record to indicate potential eligibility under the DAC provisions. All cases will typically have a current or former RSDI claim number suffix beginning with "C," e.g., C1. The onset date of disability can be assumed to have been prior to age 22.

You should determine eligibility in the same way as a Pickle case, disregarding the amount of the DAC benefit, or increase in benefit that made the individual ineligible for SSI. Use Action Reason 13.

If SDX document information is not available or is insufficient to determine eligibility, contact the Policy Hotline at Central Office for assistance.



8600 REIMBURSEMENT PROCEDURES

(Reserved)



DESCRIPTION OF SOCIAL SECURITY CLAIM ACCOUNT SUFFIXES

Following is a listing of social security claim number suffixes, also known as Beneficiary Identification Codes (BIC's) and Payment Identification Codes (PIC's).

CODE	TYPE	IDENTIFICATION
&or 0	Wage Earner and Spouse	Retirement or disability
A	Wage Earner (Primary)	Retirement or disability
B	Aged Wife	First claimant
B1	Husband	First claimant
B2	Young Wife	Second Claimant
B3	Aged Wife	Second Claimant
B4	Husband	Second Claimant
B5	Young Wife	Second Claimant
B6	Divorced Wife	First Claimant
B7	Young Wife	Third Claimant
B8	Aged Wife	Third claimant
B9	Divorced Wife	Second claimant
BA (B10)	Aged Wife	Fourth claimant
BD (B13)	Aged Wife	Fifth claimant
BG (B16)	Aged Husband	Third claimant
BH (B17)	Aged Husband	Fourth claimant
BJ (B19)	Aged Husband	Fifth claimant
BK (B20)	Young Wife	Fourth claimant
BL (B21)	Young Wife	Fifth claimant



<u>CODE</u>	<u>TYPE</u>	<u>IDENTIFICATION</u>
BQ (B26)	Divorced Wife	Fifth claimant
BR (B27)	Divorced Husband	First claimant
BT (B29)	Divorced Husband	Second claimant
C1-C9	Child	Includes disabled or student child
CA-CK (C1-C20)		
D	Aged Widow	First claimant
D1	Widower	First claimant
D2	Aged Widow	Second claimant
D3	Widower	Second claimant
D4	Widow	Remarried after attainment of age 60
D5	Widower	Remarried after attainment of age 60
D6	Surviving Divorced Wife	First claimant
D7	Surviving Divorced Wife	Second claimant
D8	Aged Widow	Third claimant
D9	Remarried Widow	Second claimant
DA (D10)	Remarried Widow	Third claimant
DD (D13)	Aged Widow	Fourth claimant
DG (D16)	Aged Widow	Fifth claimant
DH (D17)	Aged Widower	Third claimant
DJ (D19)	Aged Widower	Fourth claimant
DK (D20)	Aged Widower	Fifth claimant
DL (D21)	Remarried Widow	Fourth claimant

<u>CODE</u>	<u>TYPE</u>	<u>IDENTIFICATION</u>
DN (D23)	Remarried Widow	Fifth claimant
DP (D25)	Remarried Widower	Second claimant
DQ (D26)	Remarried Widower	Third claimant
DR (27)	Remarried Wiower	Fourth claimant
DT (D29)	Remarried Widower	Fifth claimant
DV (D31)	Surviving Divorced Wife	Third claimant
DW (D32)	Surviving Divorced Wife	Fifth claimant
DY (D34)	Surviving Divorced Wife	Fifth claiant
E	Widowed other	First claiant
E1	Surviving Divorced	First claimant Mother
E2	Widowed Mother	Second claimant
E3	Surviving Divorced	Second claimant Mother
E4	Widower Father	First claimant
E5	Surviving Divorced	First claimant father (Widower)
E6	Widowed Father	Second claimant
E7	Widowed Mother	Third claimant
E8	Widowed Mother	Fourth claimant
E9	Surviving Divorced	Second claimant Father (Widower)
EA (E10)	Widowed Mother	Fifth claimant
EB (E11)	Surviving Divorced	Third claimant Mother
EC (E12)	Surviving Divorced	Fourth claimant Mother
ED (E13)	Surviving Divorced	Fifth claimant Mother
EF (E15)	Widowed Father	Third claimant

<u>CODE</u>	<u>TYPE</u>	<u>IDENTIFICATION</u>
EG (E16)	Widowed Father	Fourth claimant
EH (E17)	Widowed Father	Fifth claimant
EJ (E19)	Surviving Divorced	Third claimant Father (Widower)
EK (E20)	Surviving Divorced	Fourth claimant Father (Widower)
EM (E22)	Surviving Divorced	Fifth claimant Father (Widower)
F1	Father	
F2	Mother	
F3	Stepfather	
F4	Stepmother	
F5	Adopting Father	
F6	Adopting Mother	
F7	Second Alleged Father	
F8	Second Alleged Mother	
G1-9	Claimants of Lump-Sum Death Benefits (PIC Only)	
J1	Primary Prouty entitled to deemed HIB	Less than three quarters to of coverage
J2	Primary Prouty entitled to deemed HIB	Over two quarters of coverage
J3	Primary Prouty not to deemed HIB	Less than three quarters entitled of coverage
J4	Primary Prouty not entitled to deemed HIB	Over two quarters of coverage
K1	Prouty wife entitled to deemed HIB	Less than three quarters of coverage
K2	Prouty wife entitled to deemed HIB	Over two quarters of coverage

<u>CODE</u>	<u>TYPE</u>	<u>IDENTIFICATION</u>
K3	Prouty wife not entitled to deemed HIB	Less than three quarters coverage
K4	Prouty wife not entitled to deemed HIB	Over two quarters of coverage
K5	Second wife entitled deemed HIB	Less than two quarters of coverage
K6	Second Prouty Wife entitled to deemed HIB	Over two quarters of coverage
K7	Second Prouty Wife not entitled to deemed HIB	Less than three quarters of coverage
K8	Second Prouty Wife not entitled to deemed HIB	Over three quarters of coverage
K9	Third Prouty Wife entitled to deemed HIB	Less than three quarters of coverage
KA (K10)	Third Prouty Wife entitled to HIB	Over two quarters of coverage
KB (K11)	Third Prouty Wife not entitled to HIB	Less than three quarters of coverage
KC (K12)	Third Prouty Wife not entitled to HIB	Over two quarters of coverage
KD (K13)	Fourth Prouty Wife entitled to HIB	Less than three quarters of coverage
KE (K14)	Fourth Prouty Wife entitled to HIB	Over two quarters of coverage
KF (K15)	Fourth Prouty Wife not entitled to HIB	Less than three quarters of coverage

## MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

APPENDIX 1

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<u>CODE</u>	<u>TYPE</u>	<u>IDENTIFICATION</u>
KG (16)	Fourth Prouty Wife not entitled to HIB	Over two quarters of coverage
KH (K17)	Fifth Prouty Wife entitled to HIB	Less than three quarters of coverage
KJ (K19)	Fifth Prouty Wife entitled to HIB	Over two quarters of coverage
KL (K21)	Fifth Prouty Wife not entitled to HIB	Less than three quarters of coverage
KM (K22)	Fifth Prouty Wife entitled to HIB	Over two quarters of coverage
M	Uninsured	Not qualified for demed HIB
M1	Uninsured	Qualified for but refused HIB
T	Uninsured	Entitled to HIB under
T	Uninsured	Entitled to HIB under deemed or renal provisions
W	Disabled Widow	First claimant
W1	Disabled Widower	First claimant
W2	Disabled Widow	Second claimant
W3	Disabled Widower	Second claimant
W4	Disabled Widow	Third claimant
W6	Disabled Surviving divorced Wife	First claimant



# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

## MEDICARE

### Beneficiary Identification Codes (BIC) for the Federal employee & family members

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<u>CODE</u>	<u>TYPE</u>	<u>IDENTIFICATION</u>
TA	Primary federal beneficiary not entitled to Title II or railroad monthly benefits (at time of filing).	
TB	Same as B	(1st claimant)
TG	Same as B3	(2nd claimant)
TH	Same as B7	(3rd claimant)
TJ	Same as BK	(4th claimant)
TK	Same as BL	(5th claimant)
TC	Disabled child	(1st claimant)
T2-T9	Same as TC	(2nd-9th claimant)
TD	Aged widow(er)	(1st claimant)
TL	Same as TD	(2nd claimant)
TM	Same as TD	(3rd claimant)
TN	Same as TD	(4th claimant)
TP	Same as TD	(5th claimant)
TW	Disabled widow(er)	(1st claimant)
TX	Same as TW	(2nd claimant)
TY	Same as TW	(3rd claimant)
TZ	Same as TW	(4th claimant)
TV	Same as TW	(5th claimant)
TF	Parent	(1st claimant)
TQ	Parent	(2nd claimant)
TE	Young widow(er)	(1st claimant)
TR	Same as TE	(2nd claimant)
TS	Same as TE	(3rd claimant)
TT	Same as TE	(4th claimant)
TJ	Same as TE	(5th claimant)



BOSTONREGIONCO-LOCATED OFFICES

<u>DSS OFFICE</u>			<u>DPW OFFICE</u>		
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
06	360	Boston State 123 Morton Street Jamaica Plain, MA 02130	01	480	Adams Street CSA 123 Morton Street Jamaica Plain, MA 02130 (Morton Street)
06	370	Mass Mental Health 1491 Tremont Street Roxbury, MA 02120	01	430	Roxbury Crossing CSA 1491 Tremont Street Roxbury, MA 02120
06	391	Tufts 320 Mt. Vernon St. Dorchester, MA 02125	01	441	Hancock Street CSA 320 Mt. Vernon St. Dorchester, MA 02125 (Columbia Point)
06	400	Harbor 154 Maverick St. Easton Boston, MA 02128	01	410	Church Street CSA 154 Maverick St. East Boston, MA 02128 (East Boston)

BOSTONREGIONNON-CO-LOCATED OFFICES

<u>DSS OFFICE</u>			<u>DPW OFFICE</u>		
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
06	961 PSU 965 966 967	Regional Office Protective Service Unit + Adoption 21 James Street Boston, MA 02116	01	420	Church Street CSA 20 Church Street Boston, MA 02116
06	380	Boston University 55 Dimmock Street Roxbury, MA 02119	01	490	Grove Hall CSA 615 Blue Hill Avenue Roxbury, MA 02119
06	390	Tufts 20 West Howell St. Dorchester, MA 02125	01	442	South Boston WSO 282 Broadway South Boston, MA 02127
06	381	Boston University 21 James Street Boston, MA 02116	01	420	Church Street CSA 20 Church Street Boston, MA 02116
06	401	Harbor 1 Thompson Square Charlestown, MA 02129	01	410	Church Street CSA "East Boston" WSO 156 Maverick St. East Boston, MA 02128

<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
06	964?	Subsidized Adoption 21 James Street Boston, MA 02116	01	420	Church Street CSA 20 Church Street Boston, MA 02116
09 *	995	Adoption Contracts 150 Causeway St. Boston, MA 02114			Medical Assistance Unit 41 Hawkins Street Boston, MA 02114



NEW BEDFORDREGIONCO-LOCATED OFFICES

<u>DSS OFFICE</u>			<u>DPW OFFICE</u>		
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
05	300	Brockton 75 Commerical St. Brockton, MA 02401	07	044	Brockton CSA 75 Commercial St. Brockton, MA 02401
05	320	Taunton 21 Spring St. Taunton, MA 02780	07	297	Taunton CSA 21 Spring St. Taunton, MA 02780
05	300	Fall River 66 Troy St. Fall River, MA 02721	07	097	Fall River CSA 66 Troy St. Fall River, MA 02721
05	340	New Bedford 533 Mill Streeet New Bedford, MA 02740	07	204	Bew Bedford CSA 533 Mill Street New Bedford, MA 02740
05	310	Plymouth 88 Sandwich St. Plymouth, MA 02360	07	242	Plymouth CSA 88 Sandwich St. Plymouth, MA 02360

NEW BEDFORDREGIONNON-CO-LOCATED OFFICES

<u>DSS OFFICE</u>			<u>DPW OFFICE</u>		
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
05	951 952 954 955 956 957	Regional Office Adoption and Protective Service U. Maxwell Library, Bridgewater State College Bridgewater, MA 02324	07	044	Brockton CSA 75 Commercial Street Brockton, MA 02401
05	290	Attleboro 947 Park Street Attleboro, MA 02703	07	016	Attleboro CSA 67 Mechanic Street Attleboro, MA 02703
05	310	Plymouth Plymouth Industrial Park Road Plymouth, MA 02360	07	242	Plymouth CSA 88 Sandwich Street Plymouth, MA 02360
05	350	Cape and the Islands 78 North Street Hyannis, MA 02601	07	020	Barnstable WSO 269 Barnstable Road Hyannis, MA 02601
05	341	New Bedford 399 Acushnet Aven. New Bedford, MA 02740	07	204	New Bedford CSA 533 Mill Street New Bedford, MA 02740

GREATER BOSTONREGIONCO-LOCATED OFFICES

<u>DSS OFFICE</u>			<u>DPW OFFICE</u>		
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
04	200	Mystic Valley 4 Federal Street Woburn, MA 01801	05	351	Woburn CSA 4 Federal Street Woburn, MA 01801
04	210	Metropolitan- Beaverbrook 22 Church Street Waltham, MA 02154	05	312	Waltham CSA 22 Church Street Waltham, MA 02154
04	220	Cambridge/ Somerville 51 Inman Street Cambridge, MA 02139	05	049	Cambridge CSA 51 Inman Street Cambridge, MA 02139
04	221	Cambridge/ Somerville 1 Davis Square Somerville, MA 02144	05	278	Somerville CSA 1 Davis Square Somerville, MA 02144
04	240	Greater Framingham 354A Waverly St. Framingham, MA 01701	05	102	Framingham CSA 354A Waverly St. Framingham, MA 01701

GREATER BOSTONREGIONCO-LOCATED OFFICES

<u>DSS OFFICE</u>			<u>DPW OFFICE</u>		
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
04	240	Newton-Wellesley-Weston 320 Washington St. Brookline, MA 02146	05	210	Newton CSA 320 Washington Street Brookline, MA 02146
04	260	Medfield-Norwood 866A Washington St. Norwood, MA 02062	05	223	Norwood CSA 866A Washington St. Norwood, MA 02062
04	270	Quincy-West South Shore 1458 Hancock St. Quincy, MA 02169	05	247	Quincy CSA 1458 Hancock St. Quincy, MA 02169

GREATER BOSTONREGIONNON-CO-LOCATED OFFICES

<u>DSS OFFICE</u>			<u>DPW OFFICE</u>		
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
04	940 941  946 945 947	Regional Office Protective Service U. 39 Boylston Street Boston, MA 02116  Regional Office Adoption Units 39 Boylston Street Boston, MA	01	465	Medical Assistance Unit 41 Hawkins Street Boston, MA 02114
04	230	Westborough- Marlboro Walker Building Rm. 203 255 Main Street Marlboro, MA 01752	05	173	Marlboro WSO City Hall, Room 1 Marlboro, MA 01752
04	190	Concord 39 Boylston St. Boston, MA 02116	01	465	Medical Assistance Unit 41 Hawkins Street Boston, MA 02114
04	280	South Shore East- Coastal c/o Jefferson School 200 Middle St. Weymouth, MA 02189	05	340	Weymouth WSO 1431 Pleasant Street East Weymouth, MA 02189
04	200	Mystic Valley 76 Winn Street Woburn, MA 01801	05	351	Woburn CSA 4 Federal Street Woburn, MA 01801



LAWRENCEREGIONCO-LOCATED OFFICES

<u>DSS OFFICE</u>			<u>DPW OFFICE</u>		
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
03	110	Lowell 100 Merrimack St. 2nd Floor Lowell, MA 01850	04	163	Lowell CSA 100 Merrimack St. 2nd Floor Lowell, MA 01850
03	120	Lawrence 11 Lawrence St. 3rd Floor Lawrence, MA 01840	04	152	Lawrence CSA 11 Lawrence St. 3rd Floor Lawrence, MA 01840
03	130	Haverhill 200 Main St. Haverhill, MA 01830	04	131	Haverhill CSA 200 Main St. Haverhill, MA 01830
03	140	Cape Ann 186 Cabot St. Beverly, MA 01915	04	030	Beverly CSA 186 Cabot St. Beverly, MA 01915
03	161	Lynn 1 Washington Sq. Lynn, MA 01902	04	166	Lynn CSA 1 Washington Sq. Lynn, MA 01902
03	161	Chelsea 300 Broadway 2nd Floor Chelsea, MA 02150	04	057	Chelsea CSA 300 Broadway 2nd Floor Chelsea, MA 02150

<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
03	170	Eastern Middlesex 7 Lincoln St. Wakefield, MA 01880	04	309	Wakefield CSA 7 Lincoln St. Wakefield, MA 01880
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
03	180	Tri-City 64 Salem St. 2nd Floor Medford, MA 02155	04	179	Medford CSA 64 Salem St. 2nd Floor Medford, MA 02155
03	930	Regional Office Protective Ser. U. 11 Lawrence St. 3rd Floor Lawrence, MA 01840	04	152	Lawrence CSA 11 Lawrence St. 2nd Floor Lawrence, MA 01840

LAWRENCEREGIONNON-CO-LOCATED OFFICES

<u>DSS OFFICE</u>			<u>DPW OFFICE</u>		
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
03	935 936 937	Regional Office Adoption Units 143 South Main St. Middleton, MA 01945	04	232	Peabody WSO City Hall Annex Peabody, MA 01960
03	150	Danvers/Salem 2 Margin St. Salem, MA 01970	04	262	Salem WSO 209 Essex St. Salem, MA 01970
03	932	Regional Office Contracted Cases 143 South Main St. Middleton, MA 01949	04	232	Peabody WSO City Hall Annex Peabody, MA 01960

WORCESTERREGIONCO-LOCATED OFFICES

<u>DSS OFFICE</u>			<u>DPW OFFICE</u>		
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
02	060	Fitchburg 76 Summer St. Fitchburg, MA 01420	03	099	Fitchburg CSA 76 Summer St. Fitchburg, MA 01420
02	100	Worcester 9 Norwich St. Worcester, MA 01608	03	352	Worcester CSA 9 Norwich St. Worcester, MA 01608

WORCESTERREGIONNON-CO-LOCATED OFFICES

<u>DSS OFFICE</u>			<u>DPW OFFICE</u>		
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
02	921	Regional Office Protective Ser. U. 75A Grove Street Worcester, MA 01605	03	352	Worcester CSA 9 Norwich St. Worcester, MA 01608
02	070	Gardner-Athol 82 Main Street Gardner, MA 01440	03	298	Templeton WSO Post Office Box 297 South Road Templeton, MA 01468
02	080	Blackstone Valley 89 Main Street Medway, MA 02053	03	180	Milford CSA 66 Sumner Street Milford, MA 01757
02	925 926 927	Regional Office Adoption Units 75A Grove St. Worcester, MA 01605	03	352	Worcester CSA 9 Norwich Street Worcester, MA 01608
02	090	South Central Ma. P.O. Box 300 Sturbridge, MA 01556	03	282	Southbridge CSA 399 Main Street Southbridge, MA 01550



SPRINGFIELDREGIONCO-LOCATED OFFICES

<u>DSS OFFICE</u>			<u>DPW OFFICE</u>		
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
01	010	Pittsfield-Bershire County Protective Service U. 46 Summer St. Pittsfield, MA 01201	02	239	Pittsfield CSA 46 Summer Street Pittsfield, MA 01201
01	020	Franklin-Hampshire Northampton Office 355 Bridge Street Northampton, MA 01060	02	217	Northampton CSA 355 Bridge Street Northampton, MA 01060
01	030	Holyoke-Chicopee 383 Dwight Street Holyoke, MA 01040	02	140	Holyoke CSA 383 Dwight Street Holyoke, MA 01040
01	050	Westfield Box 607 42 Arnold St. Westfield, MA 01085	02	333	Westfield CSA Box 607 Westfield, MA 01085
01	915 916 917	Springfield Adoption 310 State Street Springfield, MA 01109	02	285	Springfield CSA 310 State Street Springfield, MA 01109

SPRINGFIELDREGIONNON-CO-LOCATED OFFICES

<u>DSS OFFICE</u>			<u>DPW OFFICE</u>		
<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>	<u>REG</u>	<u>WSO</u>	<u>NAME AND ADDRESS</u>
01	911	Regional Office Protective Ser. U. 365 Bay Street Springfield, MA 01109	02	285	Springfield CSA 310 State Street Springfield, MA 01105
01	040	Springfield 365 Bay Street Springfield, MA 01109	02	285	Springfield CSA 310 State Street Springfield, MA 01105
01	021	Greenfield 25-27 Bank Row Greenfield, MA 01301	02	116	Greenfield WSO 9 Bank Row Greenfield, MA 01301



TABLE I-1

SOURCES OF BIRTH AND DEATH RECORDS

<i>Place of birth or death</i>	<i>Cost of full copy</i>	<i>Cost of short form</i>	<i>Address of vital statistics office</i>	<i>Remarks</i>
Alabama .....	\$3.00	Not issued	Bureau of Vital Statistics State Department of Public Health Montgomery, Alabama 36104	Additional copies at same time are \$1.00 each. State office has records since January 1, 1908. Fee for special searches is \$3.00 per hour.
Alaska .....	\$3.00	\$3.00	Bureau of Vital Statistics Department of Health and Welfare Pouch "H" Juneau, Alaska 99801	State office has records since 1913.
American Samoa .....	\$1.00	Not issued	Office of the Territorial Registrar Government of American Samoa Pago Pago American Samoa 96799	Registrar has records on file since before 1900.
Arizona .....	\$2.00	\$2.00	Division of Vital Records State Department of Health P.O. Box 3887 Phoenix, Arizona 85030	State office has records since July 1, 1909, and abstracts of records filed in the counties before that date.

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# MASSACHUSETTS MEDICAL ASSISTANCE PROCEDURES HANDBOOK

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Place of birth or death	Cost of full copy	Cost of short form	Address of vital statistics office	Remarks
Arkansas .....			Division of Vital Records Arkansas Department of Health 4815 West Markham Street Little Rock, Arkansas 72201	State office has records since February 1, 1914, as well as some original Little Rock and Fort Smith records from 1881.
Birth.....	\$2.00	\$2.00		
Death .....	\$3.00			
California .....	\$3.00	\$3.00	Vital Statistics Section State Department of Health 410 N Street Sacramento, California 95814	State office has records since July 1, 1905. For records before that date, write to County Recorder in county of event.
Canal Zone .....	Not issued	\$2.00	Vital Statistics Clerk Health Bureau Balboa Heights, Canal Zone	Central office has records since May 1904.
Colorado .....	\$2.00	\$2.00	Records and Statistics Section Colorado Department of Health 4210 East 11th Avenue Denver, Colorado 80220	State office has death records since 1900 and birth records since 1910. State office also has birth records for some counties for years prior to 1910. \$2.00 fee is for search of files and one copy of record if found.
Connecticut .....	\$2.00	\$1.00	Public Health Statistics Section State Department of Health 79 Elm Street Hartford, Connecticut 06115	State office has records since July 1, 1897. For records before that date write to Registrar of Vital Statistics in town or city where birth or death occurred.
Delaware .....	\$2.50	\$2.50	Bureau of Vital Statistics Division of Public Health Department of Health and Social Services Jesse S. Cooper Memorial Building Dover, Delaware 19901	State office has records for 1861 to 1863 and since 1881 but no records for 1864 through 1880.
District of Columbia...	\$1.00	\$1.00	Department of Human Resources Vital Records Section Rm 1022 300 Indiana Avenue, NW. Washington, D.C. 20001	Death records on file beginning with 1855 and birth records beginning with 1871, but no death records were filed during the Civil War.
Florida .....	\$2.00	\$2.00	Department of Health and Rehabilitative Services Division of Health Bureau of Vital Statistics P.O. Box 210 Jacksonville, Florida 32201	State office has some birth records since April 1855 and some death records since August 1877. The majority of records date from January 1917. (If the exact date is unknown and more than 1 year has to be searched, the fee is \$2.00 for the first year searched and \$1.00 for each additional year searched up to a maximum of \$25.00. Fee includes a copy of the record if found.)
Georgia .....	\$3.00	\$3.00	Vital Records Unit State Department of Human Resources Room 217-H 47 Trinity Avenue SW Atlanta, Georgia 30334	The State office has records since January 1, 1919. For records before that date in Atlanta or Savannah write to the County Health Department in place where birth or death occurred. Additional copies of same record ordered at same time are \$1.00 each.

NOTE: Births occurring before birth registration was required or births not registered when they occurred may have been filed as "delayed birth registrations." Keep this in mind when seeking a copy of a record.



Place of birth or death	Cost of full copy	Cost of short form	Address of vital statistics office	Remarks
Guam .....	\$1.00	\$1.00	Office of Vital Statistics Department of Public Health and Social Services Government of Guam P.O. Box 2816 Agana, Guam, M.I. 96910	Office has records on file since October 26, 1901.
Hawaii.....	\$2.00	\$2.00	Research and Statistics Office State Department of Health P.O. Box 3378 Honolulu, Hawaii 96801	State office has records since 1853.
Idaho .....	\$2.00	\$2.00	Bureau of Vital Statistics State Department of Health and Welfare Statehouse Boise, Idaho 83720	State office has records since 1911. For records from 1907 to 1911, write to County Recorder in county where birth or death occurred.
Illinois .....	\$3.00	\$3.00	Office of Vital Records State Department of Public Health 535 W. Jefferson Street Springfield, Illinois 62761	State office has records filed since January 1, 1916. For records filed before that date and for copies of State records since January 1, 1916, write to the County Clerk in county where birth or death occurred. (\$3.00 fee is for search of files and one copy of the record if found. Additional copies of the same record ordered at the same time are \$2.00 each.)
Indiana .....	\$3.00	Not issued	Division of Vital Records State Board of Health 1330 West Michigan Street Indianapolis, Indiana 46206	State office has birth records since October 1, 1907, and death records since 1900. For records before that date, write to Health Officer in city or county where birth or death occurred. Additional copies of same record ordered at same time are \$1.00 each.
Iowa.....	\$2.00	\$2.00	Division of Records and Statistics State Department of Health Des Moines, Iowa 50319	State office has records since July 1, 1880.
Kansas.....	\$2.00	\$2.00	Bureau of Registration and Health Statistics 6700 S. Topeka Avenue Topeka, Kansas 66620	State office has records since July 1, 1911. For records before that date, write to County clerk in county where birth or death occurred.
Kentucky .....	\$2.00	\$2.00	Office of Vital Statistics State Department of Health 275 East Main Street Frankfort, Kentucky 40601	State office has records since January 1, 1911 and for Louisville and Lexington before that date. If birth or death occurred in Covington before 1911, write to City Health Department.
Louisiana .....	\$2.00	\$2.00	Office of Vital Records State Department of Health P.O. Box 60630 New Orleans, Louisiana 70160	State office has records since July 1, 1914. Birth records available for City of New Orleans from 1792, and death records from 1803.

NOTE: Births occurring before birth registration was required or births not registered when they occurred may have been filed as "delayed birth registrations." Keep this in mind when seeking a copy of a record.

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<i>Place of birth or death</i>	<i>Cost of full copy</i>	<i>Cost of short form</i>	<i>Address of vital statistics office</i>	<i>Remarks</i>
Maine .....	\$2.00	\$2.00	Office of Vital Records State Department of Health and Welfare State House Augusta, Maine 04333	State Office has records since 1892. For records before that year write to the municipality where event occurred.
Maryland .....	\$2.00	\$2.00	Division of Vital Records State Department of Health State Office Building 201 West Preston Street P.O. Box 13146 Baltimore, Maryland 21203	State office has records since 1898. Records for the City of Baltimore are available from January 1, 1875.
Massachusetts.....	\$2.00	Free	Registrar of Vital Statistics Rm. 103 McCormack Bldg. 1 Ashburton Place Boston, Massachusetts 02108	State office has records since 1841. For records prior to that year, write to the City or Town Clerk in place where birth or death occurred. Earliest Boston records available in this office are for 1848.
Michigan .....	\$2.00	\$2.00	Office of Vital and Health Statistics Michigan Department of Public Health 3500 North Logan Street Lansing, Michigan 48914	State office has records since 1867. Copies of records since 1867 may also be obtained from County Clerk. Detroit records may be obtained from the City Health Department for births occurring since 1893 and for deaths since 1897.
Minnesota .....	\$2.00	\$2.00	Minnesota Department of Health Section of Vital Statistics 717 Delaware Street, S.E. Minneapolis, Minnesota 55440	State office has records since January 1908. Copies of records prior to 1908 may be obtained from Clerk of District Court in county where birth or death occurred or from the Minneapolis or St. Paul City Health Department if the event occurred in either city.
Mississippi.....	\$2.00	\$2.00	Vital Records Registration Unit State Board of Health P.O. Box 1700 Jackson, Mississippi 39205	
Missouri .....	\$1.00	\$1.00	Bureau of Vital Records Division Of Health State Department of Public Health and Welfare Jefferson City, Missouri 65101	State office has records beginning with January 1910. If birth or death occurred in St. Louis (city), St. Louis County, or Kansas City before 1910, write to the City or County Health Department, copies of these records are \$2.00 each.
Montana.....	\$2.00	\$2.00	Bureau of Records and Statistics State Department of Health and Environmental Sciences Helena, Montana 59601	State office has records since late 1907.

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Place of birth or death	Cost of full copy	Cost of short form	Address of vital statistics office	Remarks
Nebraska .....	\$3.00	\$3.00	Bureau of Vital Statistics State Department of Health Lincoln Building 1003 "O" Street Lincoln, Nebraska 68508	State office has records since late 1904. If birth occurred before that date, write the State office for information.
Nevada .....	\$2.00	\$1.00	Department of Human Resources Division of Health - Vital Statistics Office of Vital Records Capitol Complex Carson City, Nevada 89710	State office has records since July 1, 1911. For earlier records, write to County Recorder in county where birth or death occurred.
New Hampshire .....	\$3.00	\$3.00	Department of Health and Welfare Division of Public Health Bureau of Vital Statistics 61 South Spring Street Concord, New Hampshire 03301	Copies of records may be obtained from State office or from City or Town Clerk where birth or death occurred. (\$2.00 fee is for search of files and copy of the record if found.)
New Jersey .....	\$2.00	\$2.00	State Department of Health Bureau of Vital Statistics Box 1540 Trenton, New Jersey 08625	State office has records since June 1878. (\$2.00 fee is for search of files and one copy of the record if found. Additional copies of same record ordered at same time are \$1.00 each. When the exact date is unknown the fee is an additional \$0.50 per year searched.)
			Archives and History Bureau State Library Division State Department of Education Trenton, New Jersey 08625	For records from May 1846 through May 1878, write State Department of Education.
New Mexico .....	\$2.00	\$2.00	Vital Statistics Bureau New Mexico Health Services Division P.O. Box 968 Santa Fe, New Mexico 87503	State office has records since 1880 (\$2.00 fee is for search of files and one copy of the record if found).
New York (except New York City) ..	\$2.00	\$2.00	Bureau of Vital Records State Department of Health Empire State Plaza Tower Building Albany, New York 12237	State office has records since 1880. For records prior to 1914 in Albany, Buffalo, and Yonkers or before 1620 in any other city, write to Registrar of Vital Statistics in the city where birth or death occurred. For the rest of the State, except New York City, write to State office.
New York (all boroughs) .....			Bureau of Records and Statistics Department of Health of New York City 125 Worth Street New York, New York 10013	Records on file since 1898. Additional copies of birth records ordered at same time are \$1.50 each. For Old City of New York (Manhattan and part of the Bronx) birth and death records from 1865-1897, write to the Municipal Archives and Records Retention Center of New York, 23 Park Row, New York, New York 10036
Birth .....	\$3.00	\$3.00		
Death .....	\$2.50			

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<i>Place of birth or death</i>	<i>Cost of full copy</i>	<i>Cost of short form</i>	<i>Address of vital statistics office</i>	<i>Remarks</i>
North Carolina .....	\$3.00	\$3.00	Department of Human Resources Division of Health Services Vital Records Branch P.O. Box 2091 Raleigh, North Carolina 27602	State office has records since October 1, 1913, and some delayed records prior to that date.
North Dakota .....	\$2.00	\$2.00	Division of Vital Records Office of Statistical Services State Department of Health Bismarck, North Dakota 58505	State office has some records from July 1, 1893; years from 1894 to 1920 are incomplete.
Ohio .....	\$2.00	\$2.00	Division of Vital Statistics Ohio Department of Health G-20 Ohio Departments Building 65 S. Front Street Columbus, Ohio 43215	State office has records since December 20, 1908. For records before that date, write to Probate Court in county where birth or death occurred.
Oklahoma .....	\$2.00	\$2.00	Vital Records Section State Department of Health Northeast 10th Street & Stonewall P.O. Box 53551 Oklahoma City, Oklahoma 73105	State office has records since October 1908.
Oregon .....	\$3.00	\$3.00	Vital Statistics Section Oregon State Health Division P.O. Box 231 Portland, Oregon 97207	State office has records since July 1903. State office has some earlier records for the City of Portland dating from approximately 1880. Additional copies of the same record ordered at the same time are \$2.00 each.
Pennsylvania .....	\$2.00	\$1.00	Division of Vital Statistics State Department of Health Central Building 101 South Mercer Street P.O. Box 1528 Newcastle, Pennsylvania 16103	State office has records since January 1, 1906. For records before that date, write to Register of Wills, Orphans Court, county seat where birth or death occurred. Persons born in Pittsburgh from 1870 to 1905 or in Allegheny City, now part of Pittsburgh, from 1882 to 1905 should write to the Office of Biostatistics, Pittsburgh Health Department, City-County Building, Pittsburgh, Pennsylvania 15219. For births and deaths occurring in the City of Philadelphia from 1860 to 1915, apply to Vital Statistics, Philadelphia Department of Public Health, City Hall Annex, Philadelphia, Pennsylvania 19107.
Puerto Rico.....	\$0.50	\$0.50	Division of Demographic Registry and Vital Statistics Department of Health San Juan, Puerto Rico 00906	Central office has records since July 22, 1931. Copies of records prior to that date may be obtained by writing to local Registrar (Registrador Demografico) in municipality where birth or death occurred or to central office.
Rhode Island .....	\$2.00	\$2.00	Division of Vital Statistics State Department of Health Room 101 Health Building Davis Street Providence, Rhode Island 02908	State office has records since 1853. For records before that year, write to Town Clerk in town where birth or death occurred.

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Place of birth or death	Cost of full copy	Cost of short form	Address of vital statistics office	Remarks
South Carolina .....	\$2.00	\$2.00	Division of Vital Records Bureau of Health Measurement S.C. Department of Health and Analysis Environmental Control 2600 Bull Street Columbia, South Carolina 29201	State office has records since January 1, 1915. City of Charleston births from 1877 and deaths from 1821 on file at Charleston County Health Department. Ledger entries of Florence City births and death from 1895 to 1914 on file at Florence County Health Department. Ledger entries of Newsberry City births and deaths from late 1800's on file at Newberry County Health Department. Early records are obtainable only from County Health Departments listed.
South Dakota .....	\$2.00	\$2.00	Division of Public Health Statistics State Department of Health Pierre, South Dakota 57501	State office has records since July 1, 1905, and access to other records for some births and deaths which occurred before that date.
Tennessee .....	\$2.00	\$2.00	Division of Vital Statistics State Department of Public Health Cordell Hull Building Nashville, Tennessee 37219	State office has birth records for entire State from January 1, 1914, to date and records from June 1881 for Nashville, July 1881 for Knoxville, and January 1882 for Chattanooga. State office has death records for entire State from January 1, 1914, to date and records from July 1874 for Nashville, March 6, 1872, for Chattanooga, and July 1, 1887, for Knoxville. Birth and death enumeration records by school districts from July 1, 1908, through June 30, 1912. Memphis birth records are from April 1, 1874, through December 1887; records continue November 1, 1898, to January 1, 1914. Death records date from May 1, 1848, to January 1, 1914. Apply to Memphis-Shelby County Health Department, Division of Vital Statistics, Memphis, Tennessee.
Texas .....	\$3.00	\$3.00	Bureau of Vital Statistics Texas Department of Health Resources 410 East 5th Street Austin, Texas 78701	State office has records since 1903.
Trust Territory of the Pacific Islands .....	\$0.25 plus \$0.10 per 100 words	\$0.25 plus \$0.10 per 100 words	Clerk of Court of district where event occurred. (If not sure of the district in which event occurred, write to the Director of Medical Services, Department of Medical Services, Saipan, Mariana Islands 96950, to have the inquiry referred to the correct district.)	Courts have records since November 21, 1952. Beginning 1950 a few records for various islands are temporarily filed with the Hawaii Bureau of Vital Statistics.
Utah .....	\$3.00	\$3.00	Division of Vital Statistics Utah State Department of Health 554 South Third East Salt Lake City, Utah 84113	State office has records since 1905. If birth or death occurred from 1890 through 1904 in Salt Lake City or Ogden, write to City Board of Health. For records elsewhere in the State from 1896 through 1904, write to County Clerk in county where birth or death occurred.

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<i>Place of birth or death</i>	<i>Cost of full copy</i>	<i>Cost of short form</i>	<i>Address of vital statistics office</i>	<i>Remarks</i>
Vermont .....	\$2.00	\$2.00	Town or City Clerk of town where birth or death occurred.	
	\$1.50	\$1.50	Secretary of State Vital Records Department State House Montpelier, Vermont 05602	
			Public Health Statistics Division Department of Health Burlington, Vermont 05401	For information on vital statistics laws, how to correct a record, etc., write to Department of Health.
Virginia .....	\$2.00	\$2.00	Bureau of Vital Records and Health Statistics State Department of Health James Madison Building Box 1000 Richmond, Virginia 23208	State office has records from January 1853 through December 1896 and since June 4, 1912. For records between those dates, write to the Health Department in the city where birth or death occurred.
Virgin Islands (U.S.) St. Thomas.....	\$2.00	Not issued	Registrar of Vital Statistics Charlotte Amalie St. Thomas, Virgin Islands 00802	Registrar has birth records on file since July 1, 1906, and death records since January 1, 1906.
St. Croix .....	\$2.00	Not issued	Registrar of Vital Statistics Charles Harwood Memorial Hospital St. Croix, Virgin Islands	Registrar has birth and death records on file since 1840.
Washington .....	\$3.00	\$3.00	Bureau of Vital Statistics Health Services Division Department of Social and Health Services P.O. Box 709 Olympia, Washington 98504	State office has records since July 1, 1907. In Seattle, Spokane, and Tacoma a copy may also be obtained from the City Health Department. For records before July 1, 1907, write to Auditor in county where birth or death occurred.
West Virginia .....	\$2.00	Not issued	Division of Vital Statistics State Department of Health State Office Building No. 3 Charleston, West Virginia 25305	State office has records since January 1917. For records prior to that year, write to Clerk of County Court in the county where birth or death occurred.
Wisconsin .....	\$4.00	\$4.00	Bureau of Health Statistics Wisconsin Division of Health P.O. Box 309 Madison, Wisconsin 53701	State office has some records since 1814; early years are incomplete.
Wyoming .....	\$2.00	\$2.00	Vital Records Services Division of Health and Medical Services State Office Building West Cheyenne, Wyoming 82002	State office has records since July 1909.

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